



Critical Care Clinical Quality Assurance Procedure

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1 Scope

- 1.1. The South East Coast Ambulance Service (the Trust) operates a trust-wide Critical Care Service. The service is delivered by Critical Care Paramedics (CCPs) organised in a regional Operating Unit (OU) .
- 1.2. The National Centre for Biotechnology Information (NCBI) describes Quality Assurance as 'Activities and programs intended to assure or improve the quality of care in either a defined medical setting or a program. The concept includes the assessment or evaluation of the quality of care; identification of problems or shortcomings in the delivery of care; designing activities to overcome these deficiencies; and follow-up monitoring to ensure effectiveness of corrective steps.
- 1.3. CCPs operate with an enhanced scope of clinical practice and an extended formulary which in turn requires an enhanced range of quality assurance processes to ensure clinical effectiveness and patient safety.
- 1.4. This procedure outlines the quality assurance process of CCP clinical practice.

2 Procedure

- 2.1. Quality assurance processes should be embedded within routine management activity and form an integral element of clinical governance.
- 2.2. Managers at all levels have some responsibility for conducting, recording and analysing quality assurance activity and undertaking any actions that may result.
- 2.3. Quality assurance can be provided at various stages and in varying degree of detail.
 - Patient records and activity reports
 - Clinical performance indicators
 - 1st Line quality assurance
 - 2nd line quality assurance
 - Senior review
 - Peer review
 - Case review forum
 - Skills assurance time
 - Clinical Supervision
 - Clinical audit, service evaluation and quality improvement
- 2.4. Quality assurance activity, responsibility and accountability will vary with role.

3 Clinical Performance Indicators

- 3.1. Clinical performance indicators (CPI) are set criteria used to measure compliance on a specific aspect of care delivery. They follow criterion-



based audit methodology and derive if an aspect of care is compliant or non-compliant with a specified standard.

- 3.2. CPI criteria has been derived from best practice guidance and agreed by the Critical Care Governance Sub-Group.
- 3.3. CPIs will also incorporate Ambulance Quality Indicator criteria where appropriate, to ensure these are captured and to avoid duplication.
- 3.4. A list of CPIs and a guide on completion can be found in Appendix A – ‘*Guidance for undertaking CPIs*’.

4 Patient Records and Activity reports

- 4.1. CCPs record their clinical care and decision making using the Trust ePCR platform, or paper PCR in the event of ePCR failure. ePCRs can be used individually for case review or a report can be produced from the ePCR database. With the appropriate processes, this data can be used for the purposes of clinical quality assurance, case review/discussion, clinical audit, service evaluation and quality improvement.
- 4.2. Only those with appropriate authority and with a legitimate need should access patient records with patient identifiable data, in line with the Trust’s Information Governance policies and procedures.
- 4.3. For the purposes of case review/discussion, this should be led by CC-TL, CC-COM or Consultant and using patient records that are redacted of patient identifiable data.
- 4.4. For the purposes of clinical audit, service evaluation and quality improvement, approval will be needed through the appropriate governance groups and a DPIA may be required.
- 4.5. CCPs should follow Trust guidance on the appropriate standard for documenting care on the ePCR (or paper record in the event of ePCR failure).
- 4.6. Activity reports allow for targeted review of specific elements of practice. These can be produced on the Power BI platform. These allow for the use of an element of practice, i.e., a drug, to be reviewed over a specified time frame. This report links to the CAD and ePCR record to allow the case(s) to be reviewed.

5 1st Line Quality Assurance

- 5.1 1st line quality assurance relates to the initial informal review of clinical practice, the purpose of which is to highlight any urgent patient safety concerns, identify a need for staff welfare support and to provide informal feedback on practice.
- 5.2 This may take several forms, including:
 - Review of patient care records and clinical performance indicator monitoring.
 - Informal debrief of a clinical case.



- Completion of workplace-based assessments (WPBA).

5.3 This activity would normally be conducted by a first line manager or clinical supervisor/mentor.

5.4 All quality assurance activity should be recorded.

6 2nd Line Quality Assurance

6.1. 2nd line quality assurance relates to the more formal review of clinical practice, the purpose of which is to either scrutinise a specific area of practice or identify themes in practice within an individual or across multiple clinicians and provide assurances on clinical quality, safety and effectiveness.

6.2. This may take several forms, including.

- Review of patient care records.
- Review of CPI outcomes.
- Focused areas of scrutiny, e.g., high risk interventions.
- Formal debrief of a clinical case.
- Collective review of cases to capture compliance and themes.

6.3. This activity would normally be conducted by a member of the Critical Care Leadership Team.

6.4. 2nd line quality assurance should form part of both daily and monthly management processes and should be recorded on the Trust approved platform(s).

7 Senior Review

7.1. Senior review relates to quality assurance activity undertaken by a member of the Critical Care Consultant Team (Consultant Paramedic, Assistant Medical Director, Top Cover Consultants), the purpose of which is to obtain assurance on clinical quality, safety and effectiveness, explore themes in practice and provide a second or senior opinion.

7.2. This may take several forms, including.

- Focussed review of patient care records for a specific reason.
- Focussed areas of scrutiny, e.g., high risk interventions.
- Formal debrief of a clinical case.
- Collective review of cases to capture compliance and themes.

5.3 This activity would normally be conducted by the Consultant Paramedic or Assistant Medical Director with responsibility for critical care practice, however, may be undertaken by the Chief Medical Officer or any member of the Consultant team.



- 7.3. Senior review should form part of routine monthly quality assurance processes and provide ultimate assurance of clinical effectiveness and patient safety to the Chief Medical Officer and the Trust Board.

8 Peer Review

- 8.1. Peer review relates to informal review of clinical or operational practice undertaken between colleagues of the same grade.
- 8.2. Peer review may take place locally between two or more individual clinicians or centrally during a case review forum.
- 8.3. Peer to peer operational ride outs form part of both governance and welfare activity and are scheduled as part of governance rotations.
- 8.4. At the beginning of a peer to peer shift the 'dual CCP shift checklist' (Appendix B) should be carried out to ensure mutual understanding of clinical primacy and objectives for the day. This provides clarity on roles, therefore avoiding confusion at scene, whilst ensuring the shift is productive.
- 8.5. During a peer-to-peer shift, activity should be evidenced through the completion of a Microsoft Form (Appendix C)
- 8.6. Peer review is an important aspect of personal quality assurance of practice, however, there are limitations with regard oversight.
- 8.7. Peer review should form part of regular personal quality assurance and learning activity, however, should not be relied upon for assurance.
- 8.8. Patient identifiable data should not be used during peer review activity.

9 Clinical Governance Time

- 9.1. Formal clinical governance time is essential activity for CCPs to practice safely and to provide assurance to the Trust. This time is also essential for providing support for welfare and wellbeing.
- 9.2. CCPs are organised into seven clinical governance teams. Formal clinical governance time is scheduled each week, with each CCP governance team rotating through each 7 weeks.
- 9.3. Each formal clinical governance week can include:
- 9.3.1. Case review forum
 - 9.3.2. Skills assurance time
 - 9.3.3. Peer to peer shift, uplift training (i.e., introduction of a new device or intervention) or mandatory training.



10 Case Review Forum

- 10.1. The case review forum is planned activity within the regular governance time that all CCPs are required to attend.
- 10.2. The case review forum is conducted weekly and attended on a rotational basis. Case review forums are a mandatory component of individual CCP governance time and forms a part of clinical currency.
- 10.3. The purpose of the case review forum is to allow individual clinicians to present a clinical case that they have attended, with the intent that this is both senior and peer reviewed and discussed, to identify and share learning.
- 10.4. Cases may either be selected by the individual clinician or the critical care leadership team. Each forum will include a mix of cases.
- 10.5. This activity is led and overseen by one of the critical care leadership team and supported by the Consultant Team.
- 10.6. All cases that are discussed are captured along with any notes on the Critical Care Governance database. Pertinent learning points are anonymised and are circulated to the Critical Care Leadership Team at the end of each governance rotation by the Critical Care Team Leader responsible for leading the case review. Once reviewed the Critical Care Clinical Operations Manager will circulate them to all CCPs.

11 Skills Assurance Time

- 11.1. Skills assurance time relates to formal teaching and/or assessment time regarding a core specialist skill with the purpose of providing assurance of competence in that skill/intervention.
- 11.2. Skills assurance time is a mandatory component of individual CCP governance time and forms a part of clinical currency.
- 11.3. Skills assurance time is required in the following skills.
 - Surgical cricothyroidotomy
 - Open thoracostomy
 - Adult laryngoscopy and endotracheal intubation
 - Paediatric laryngoscopy and endotracheal intubation
 - Advanced Life Support
- 11.4. Skills assurance time may be added on an ad-hoc basis for other skills and interventions as required to ensure competence and provide assurance.
- 11.5. Skills assurance time should be logged on the Critical Care Governance database.

12 Clinical Supervision



- 12.1. Clinical supervision in the context of this policy refers only to direct supervision of practice.
- 12.2. The purpose of direct supervision is to observe the clinical practice of an individual clinician in order to provide guidance, critique, reassurance, support and feedback in a structured way.
- 12.3. Clinical supervision may be undertaken for four primary reasons; (1) a routine planned supervision shift, (2) as part of a specific action plan (3) to support a return or transition to practice following an absence from the role or (4) as part of a programme of training.
- 12.4. Clinical supervision should normally be undertaken by a named mentor/supervisor, a CCTL, a CC-COM or one of the Consultant Team.
- 12.5. At the beginning of a supervision shift the 'duel CCP shift checklist' (Appendix B) should be carried out to ensure mutual understanding of clinical primacy and objectives for the day. This provides clarity on roles, therefore avoiding confusion at scene, whilst ensuring the shift is productive.
- 12.6. A supervised shift would be documented on an OSAT form (Appendix D) and recorded in the critical care governance database. This excludes those on a programme of training as this will be recorded in the individual's logbook.

13 Clinical Audit, Service Evaluation and Quality Improvement

- 13.1. Clinical audit, service evaluation and quality improvement are informed by quality assurance processes or provide a mechanism to identify areas for improvement.
- 13.2. Clinical audit, service evaluation and quality improvement are essential pillars of clinical governance and should form part of quality assurance processes.
- 13.3. The Critical Care leadership team should work in partnership with the Trust leads for clinical audit, research and quality improvement to ensure there is a programme of activity embedded within critical care governance systems.

14 Definitions

- 14.1. **CC-COM** - Critical Care Clinical Operations Manager – An Advanced Paramedic with responsibility for the service delivery and oversight of day-to-day clinical governance of critical care services within the Trust.
- 14.2. **CCTL** – Critical Care Team Leader, a specialist Paramedic with responsibility for 1st line management of CCPs and leading on clinical governance weeks.
- 14.3. **CCP** – Critical Care Paramedic, a specialist paramedic role practicing with a defined scope of practice, specifically targeted at the high acuity patient caseload.
- 14.4. **OU** – Operating Unit.



- 14.5. **CCD** – Critical Care Desk. This is a tasking and clinical advice desk operated by one or more CCPs.
- 14.6. **WPBA** – Work place based assessment – a means of documenting formative assessment and supervision activity.
- 14.7. **DPIA** – Data Protection Impact Assessment.

15 Responsibilities

- 15.1. The **Chief Executive Officer** is accountable for the overall effectiveness of this procedure.
- 15.2. The **Executive Medical Director** is responsible for managing this procedure.
- 15.3. The **Consultant Paramedic for Critical Care & Resuscitation** has responsibility for implementation of this policy.
- 15.4. The **Critical Care Clinical Operations Manager** has responsibility for overseeing this policy on a day to day basis. This includes promoting and upholding compliance.
- 15.5. All **CCPs** are responsible for adhering to this procedure.

16 Audit and Review (evaluating effectiveness)

- 16.1. This procedure once implemented, will be subjected to an ongoing review of its effectiveness. This will be the responsibility of the Critical Care Governance Sub Group.
- 16.2. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).
- 16.3. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the procedure is not working effectively.
- 16.4. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.



Appendix A - Guidance for undertaking CPIs

[CCP CPI Guidance](#)

Appendix B – Dual CCP Shift Checklist

Critical Care Dual-CCP shift Checklist	
Navigation:	<ul style="list-style-type: none"> Do we need more information on scene location?
	<i>(Utilise MDT OS Maps / Google Maps / W3W on iPad)</i>
	<ul style="list-style-type: none"> Triage from scene: what hospitals are nearby: distance / times?
Equipment:	<ul style="list-style-type: none"> What equipment shall we bring to scene?
	<ul style="list-style-type: none"> Who will keep the vehicle keys / radio?
Role allocation:	<ul style="list-style-type: none"> Who is the Lead Clinician?
Desk updates:	<ul style="list-style-type: none"> Who will pass scene updates to CCD?
Additional Resources:	Discuss likelihood of any additional resources you may require when at scene
	<ul style="list-style-type: none"> <i>(e.g. more DCAs, OTLs, HEMS, another CCP)</i> <i>(other agencies? Police / Fire / Coastguard)</i>
PPE:	<ul style="list-style-type: none"> What PPE shall we use?



Appendix C – Reporting of peer to peer shift

Peer supervision

The survey will take approximately 4 minutes to complete.
This form should be completed when a CCP is conducting a 'peer to peer ride out' and should be submitted as soon as practicable after the end of the shift. It is not for use when 'supervising' a member of your team.

* Required

* This form will record your name, please fill your name.

1. Date of shift? *

2. Name of CCP on core shift? *

3. Name of supernumerary CCP? *

4. Please briefly summarise the incidents you attended on the shift? *

5. Please briefly outline the content of any clinical discussions on the shift?

6. Please briefly outline the content of any other critical care activity on the shift? (e.g. moulage)

7. Any further comments?

This content is neither created nor endorsed by Microsoft. The data you submit will be sent to the form owner.





Appendix D – Supervision Form

Supervised Shift Record

CCP	
Date	
Call sign	
Supervisor	
Specific elements team want to focus on	
Timeline of shift	
Review of daily routine	
Review of training record	
Summary of operational activity	
Training undertaken	
Other activity undertaken	



Non-technical skills	
Key lessons learned	
Clinical	
Non-technical skills	
Developmental needs	

A copy of this form should be forwarded to the individual and placed in the appropriate section of MS Teams.