NHS
South Central
Ambulance Service
NHS Foundation Trust

CARE PATHWAY
POLICY AND PROCEDURES
(CSPP NO. 7)

South Central Ambulance Service NHS Foundation Trust
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DOCUMENT INFORMATION

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- Review date changed from 2018 to 2020, updated – all
- SCAS Connect and MIDO added to aid localised decision making
- Updated to reflect new pathways section 1.2
- Added CCC clinicians as a source of advice
- Updated to reflect Clinical Memo 173. Section 4.5
- Updated NEWS2 score. Score 5 or more should be transported to hospital with consideration of a pre-alert, Appendix A.19
- Observations spaced 15 minutes apart, with a minimum of 2 sets of physiological observations at least 15 mins apart. Section 5.4
- MCA in patients who refuse medical care. An MCA should be performed where treatment or advice is declined. Section 7.9
- Added cautions re panic attack diagnosis. Exclude medical causes. Appendix A
- Freedom to Speak Up Guardian added. Whistleblowing. Section 6.2
- Falls referrals. Added other HCP as well as falls teams. Section 4.21

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- Attendance <24 hours. Added to CSD and frontline sections. Sections 5.39, 4.33
- NQP Validation. Added to appendices. Appendix
- THQP Validation. Added to appendixes. Appendix

1.0 PURPOSE

1.1 The purpose of this policy is to ensure that patients receive the right treatment (appropriate to their needs) in the right place, at the right time delivered by the most appropriate practitioner or provider service.

1.2 Pre-hospital care is continuously changing with increasing numbers of patients now being managed in the community setting, rather than at hospital. The decision as to whether patients do or do not need to be conveyed to hospital is challenging and can be further influenced by the availability of primary care and locality providers. For many patients it is now appropriate to consult with the patient's own GP or Out of Hours (OOH) provider before a conveyance decision is made; this is GP Triage.

SCAS fully support clinical decision making in-line with current practice, protocols and policies aligned to the ambulance clinician's role. If a clinician makes the decision that a patient with a non-life-threatening presentation requires further medical level interventions or diagnostics, then consultation with the GP or OOH provider, before the conveyance decision is made, can help to determine where the most appropriate patient care is delivered and by who. It is recognised that the level of GP consultation will vary across different clinical roles.

Consultation can provide access for many more patients to GP level alternative care pathways, with a range of community-based clinicians, specialists and provider services available

In today's modernised healthcare system, presenting an ambulance patient at an Emergency Department (ED) as a matter of course, is now only acceptable on the basis of an evidenced, definitive patient need for treatment or assessment, where the ED is the only suitable locality provider. ED is one pathway, within a whole range of pathways. Localised pathways can be found on SCAS Connect, which is directly linked to the Mobile Directory of Services (MIDOS)

This policy is designed:

- to minimise risks and to provide appropriate support for our staff
- to ensure dispositions and treatment options must maintain the dignity of individual or group of patients at all times and take into consideration the patients personal and social care needs
- to ensure that every patient is treated with compassion, delivered in a way that meets their expectations, ensuring all patients have as positive a patient experience as possible

1.3 Suitable dispositions for patient referral include:

- Primary Care – GP
- OOH's (via GP Triage)
- Specialist Practitioners (Previously ECPs)
- Clinical Support Desks (CSD's);
- Minor Injuries Units (MIU's);
- Primary Care Centres (PPC's);
- Walk-In Centres (WiC's);
- Urgent Care Centres (UCC's)

- District nursing services,
- Intermediate care teams.
- Social services.
- Community mental health teams,
- End of life community / hospice teams
- Emergency Multidisciplinary Units (EMU's)
- 111.

Access details for these services will be via: 111, Directory of Services, SCAS Connect or NHS Choices.

1.4 This policy also gives guidance to clinical staff in relation to patients who refuse treatment and appropriate steps to be considered to safeguard the patient.

2.0 SCOPE

2.1 This policy applies to all SCAS clinical staff including Clinical Coordination Centre (CCC) clinicians triaging public emergency 999 calls and ambulance staff attending any patient passed to them by the CCC as an "emergency or Ambulance disposition" or for any patient or case i.e. any other incident where ambulance staff are requested or feel obliged to offer assistance, treatment or advice.

2.2 This Policy DOES NOT include GP urgent calls but can include any calls passed through as an "emergency or ambulance disposition" including calls from GP surgeries, out of hours services and 111.

3.0 DUTIES

3.1 Accountability for clinical pathways is the responsibility of all clinical staff using them, ensuring that they adhere to the guidance provided or justifying their clinical decision for deviating from agreed clinical guidance. Any deviation needs to be followed by a referral to other healthcare provider to continue care.

3.2 **Director of Quality and Patient Care**

The Director of Quality and Patient Care has Board level responsibility for the review and implementation of clinical guidance within South Central Ambulance Service NHS Foundation Trust. The Director of Quality and Patient Care also chairs the Patient Safety Group with responsibility for ensuring the guidelines are in line with current best practice.

3.3 **Chief Operating Officer**

The Chief Operating Officer and Directors of Operations have delegated responsibility for managing the strategic development and implementation of clinical and non-clinical operational policies and should apply this policy throughout the Trust ensuring it is available to staff across the Trust and adhered to.

3.4 **Head of CCC**

The Heads of the CCCs will be responsible to the Chief Operating Officer for the

development of effective Trust-wide policies and procedures. Specific responsibilities will include monitoring compliance of this policy and the performance management of staff.

3.5 Heads of Operations

Heads of Operations are responsible for implementing this policy within the operational department. They report to the Chief Operating Officer and should make this policy available to all staff within their department. Heads of Operations should read and understand this policy with specific responsibilities to monitoring all areas of this policy and the performance management of staff.

3.6 Doctors

Doctors who work for the Trust must follow their clinical practices guidelines. They should be aware of this policy in line with their own clinical practices and develop an appropriate clinical pathway for the patient.

3.7 Specialist Practitioners (previously ECPs)

Specialist Practitioners are required to read and adhere to this policy while practicing. Specialist Practitioners provide both frontline clinical care but also rotate through the CCCs providing expertise to CCC and frontline staff.

3.8 Clinical Coordination Centre (CCC) Clinicians

Clinical Support Desks (CSDs) are based in both of the CCC's . *The CCC clinicians must have a* Specialist Practitioner*, Paramedic or Nursing background. In addition to this, SCAS also have access to Midwives and Mental Health Practitioners within the control room. The role of the CCC clinician is to enhance the clinical telephone assessment of complex calls made by patients. There are occasions where incidents are inappropriately graded by NHS Pathways (NHSP) where a clinician can intervene to enhance the clinical safety of all patients who make contact with the CCC's in SCAS. CCC clinicians also refer patients to alternative care pathways, where an emergency response and admission to acute hospital emergency departments is not appropriate. The CCC clinicians also provide telephone support to frontline emergency crews who require advanced clinical information to help them treat their patients most effectively.* All *CCC* clinicians should read and adhere to this policy at all times.

3.9 Paramedics

Qualified Paramedics are required to read and adhere to this policy while practicing. Student Paramedics should always work with a qualified clinician and therefore do not diagnose or treat patients in isolation and should be aware of this policy and it implications to other clinicians.

3.10 **Newly Qualified Paramedics** (NQP)

Paramedics who are newly qualified (less than 2 years post qualification) will be expected to read and adhere to this policy. In addition, they will discuss their non-conveyance decisions for high-risk patients (see appendix) with the Clinical Validation Line (CVL) of the Urgent Care or Clinical Support Desks.

3.11 Ambulance Nurses

Ambulance Nurses are required to read and adhere to this policy while practicing.

3.12 **Technicians / Associate Ambulance Practitioners (AAPs)**

Technicians are required to read and adhere to this policy while practising. Trainee Associate Ambulance Practitioners should always work with a qualified clinician and therefore do not diagnose or treat patients in isolation and should be aware of this policy and its implications to other clinicians.

3.13 ***Emergency Care Assistants***

Emergency Care Assistants provide assistance to qualified members of listed staff above and can be deployed as a dual ECA crew to deal with GP admissions and to provide back up to solo responders. Emergency Care Assistants do not diagnose or treat patients in isolation and therefore should be aware of this policy and its implications to other clinicians. 3.14 **Clinical Review Group**

The Clinical Review Group will assess the relevance of clinical guidelines and co-ordinate the production of gap analysis and action plans for the Quality and Safety Committee to monitor.

3.15 ***Patient Safety Group***

The Patient Safety Group (PSG) will monitor the implementation of relevant guidelines, within the Trusts clinical governance structure. The PSG Committee will monitor the effectiveness of clinical guidance ensuring that the Trust Board is aware of any significant non-compliance as a result of audit activity.

Staff listed above will use the relevant guidance and policies and remain in scope for their area of practise to support their clinical decision-making.

4.0 CARE PATHWAY PROCEDURE: CLINICAL SUPPORT DESK

4.1 This section covers those instances where a *CCC clinician* decides that an emergency / ambulance response or transport by ambulance to a treatment centre is not appropriate. The *CCC clinician working on the* Clinical Support Desk clinicians use NHS Pathways protocols for their telephone triage. The Urgent Care Desk (UCD) staff use locally developed pathways for validation.

4.2 Patients should only be left at home (or the scene) after an assessment has been conducted by the *CCC clinician* on the telephone and logged against the incident on the CAD system

4.3 **Special consideration must be paid towards**:

Patients suffering from dementia, Parkinson’s disease **or any disease which affects cognitive function** should be considered a “high risk” patient group. They may be difficult to accurately assess, especially with telephone triage, therefore it is advised that this patient group should be assessed by either a GP (GP Triage) or at a hospital in order to reduce the potential clinical misdiagnosis. This rule should also apply for patients suffering from mental health problems in general, or who appear to be significantly impaired by alcohol or drugs. The trust has guidelines in line with the Mental Capacity Act, 2005 for both operational crews and the *CCC clinician*s. (see 6.12 of this policy “operational guidance ref patients with mental capacity issues”)

4.4 If a child has been seen face to face by a health care professional within the previous 24 hours and has exacerbated or non-improved symptoms it would be appropriate (on the 2nd call) for the child to be conveyed to an assessment facility, such as those listed in 1.3, or an ED.

4.5 All children under the age of 2 who do not require hospital assessment should have their proposed non-conveyance decision confirmed, ideally from the patient's own GP, OOH, the GP triage service. Should this not be possible, thresholds for transporting such children to the nearest Emergency Department for further assessment should be extremely low.

4.6 Ambulance staff should be extremely cautious when dealing with patients who have been in contact with a number of health care professionals or services over a period of time, with no apparent resolution or improvement. Ambulance staff should consider escalation to an assessment facility, such as those listed in 1.3

4.7 If the *CCC clinician* has any doubt about the patients' condition, the patient MUST BE assessed by an appropriate clinician face-to-face to assess their healthcare needs.

4.8 A list of conditions that would normally require further Doctor-level investigation, diagnostics or assessment can be found in Appendix A. This list is not an exhaustive guide and will be updated via the Operational Directive process and a bi-annual review of this policy.

4.9 If another healthcare professional (such as those listed in 1.3) has advised the patient to make an emergency call and it is subsequently established by the *CCC clinician* that the call is not an emergency that requires transportation to hospital, the original referrer should be consulted so that a mutually agreed plan of action can be made (consider GP Triage). The action plan must be confirmed and logged against the incident on the CAD system in case of later enquiry. When the original referrer (such as those listed in 1.3) is no longer available, the *CCC clinician* should contact the relevant agency informing them of the nonconveyance decision.

4.10 If the *CCC clinician* decides that urgent GP follow up is required, then GP consultation (GP Triage) should be attempted. If GP Triage fails for any reason, then the patient should be seen as not appropriate to be left at home and they should be conveyed to an appropriate healthcare setting, such as those listed in 1.3 or an ED. If the clinician considers that it may not be safe to leave a patient unattended then arrangements must be made for the patient to be transported to an appropriate healthcare setting, such as those listed in 1.3 or an ED.

4.11 It is acceptable for the *CCC clinician*, in consultation with the patient and/or carer, to arrange an alternative response from the CCC. This may include a Specialist Practitioner or GP, but it must be established that there is no immediate risk to the patient. Details of such arrangements must be logged against the incident on the CAD system

4.12 If an alternative response is required, the relevant healthcare provider should be contacted, and they should be provided with the clinical findings, history and reasons for the visit / contact request. Incident number and contact details should also be provided for the return call. Details of such arrangements must be logged against

the incident details on the CAD system**.**

4.13 In the event that delays are experienced with the return call, the situation must be discussed with the patient/carer and the communication centre for an action plan to be agreed, as appropriate. An example may be “welfare checking” via the CCC / Clinical Support Desk). Details of such arrangements must be logged against the incident on the CAD system

4.14 The *CCC clinician* should ensure that the patient is given relevant advice and contact details should their condition deteriorate. This must include that if there are any new symptoms, or if the condition gets worse, changes or they have any other concerns, to call back on 111 or 999.

4.15 The *CCC clinician* should ensure that the patient is given relevant advice and contact details should their condition deteriorate.

4.16 When referring a patient to their GP or OOH GP (GP Triage), the downstream clinician will often ‘phone the patient instead of visiting or arrange an alternative assessment via district nursing, mental health, domiciliary consultant, admission to nursing home etc. Therefore, *CCC clinician* should not promise a GP visit as this is up to the downstream clinician’s clinical judgment.

4.17 If the *CCC clinician r*equests a Specialist Practitioner, it is not generally expected that the Specialist Practitioner will travel under emergency conditions, unless specifically requested by the *CCC clinician*.

4.18 The *CCC clinician* must document that the patient has been assessed and alternative care pathways organised on the incident log on the CAD.

4.19 Any written or verbal advice given to the patient / carer must be recorded by the *CCC clinician* against the incident log on the CAD.

4.20 If a patient has fallen then the *CCC clinician* must satisfy themselves that the patient has not sustained an injury, their mobility is the same as their pre-fall presentation and there is a low index of suspicion that a fall will re-occur imminently. If this is not the case, then the patient should be referred to an appropriate service or consideration given to a face to face / conveyance decision.

4.21 All patients that have sustained a fall aged 65 or over but are uninjured or left at home should be referred to their local falls service or suitable healthcare professional at the earliest opportunity.

4.22 A social history assessment may include such details as mobility and any aids used, home help, carers, family support and general living environment. This social history (SHx) should be documented appropriately on the CAD log against the incident. Special consideration should be made for the elderly, mental health patients and people of no fixed abode as these are high risk groups.

4.23 If it is necessary to re-attend a patient who has been dealt with by an ambulance clinician in the previous 24 hours (either over the phone or face to face) then staff should ensure that these cases are recorded on the Trust’s Incident reporting system, Datix, at the earliest opportunity.

5.0 CARE PATHWAY PROCEDURE: OPERATIONAL STAFF

5.1 This section covers those instances where SCAS clinicians are face to face with the patient. The most senior clinician on scene (as recognised by SCAS i.e. Specialist Practitioner, Paramedic, Nurse or Doctor) has overall responsibility for the care pathway determined for the patient.

5.2 Patients should only be left at home (or the scene) after a thorough assessment has been conducted by the attending clinician with all documentation having been fully completed. Guidance of the relevant investigations that are required is contained in the SCAS Clinical Investigation Tool (appendix D).

5.3 The Clinical Investigation Tool is used to identify the investigations that ***should*** be performed on all patients and is included in Appendix D. All staff should complete the investigations highlighted as "recommended" and should consider the other highlighted fields. This tool covers the most common conditions that our staff attend but is not an exhaustive list.

5.4 **Two full sets of physiological observations ideally spaced at least 15 minutes apart <u>must</u>** be performed for all patients who are discharged at the scene unless the clinician can justify reasons otherwise. This reason must be documented clearly in the patient's notes.

5.5 If a comprehensive assessment has not been completed by the attending crew then an explanation **must** be recorded on the ePR or (if using paper documentation) the CAS 101/ 102.

5.6 Specialist Practitioners must always complete ePR or (if using paper documentation) the CAS 101/ 102.

5.7 Special consideration must be paid towards:

5.8 Patients suffering from dementia, Parkinson's disease **or any disease which affects cognitive function** should be considered a "high risk" patient group. They may be difficult to accurately assess, therefore it is advised that this patient group should be assessed by either a GP (GP Triage) or at a hospital (after GP consultation) in order to reduce the potential clinical misdiagnosis. This rule should also apply for patients suffering from mental health problems, or who appear to be significantly impaired by alcohol or drugs. The trust has guidelines in line with the Mental Capacity Act, 2005 for both operational crews and the CSD clinicians.

5.9 If a child has been seen face to face by a health care professional within the previous 24 hours and has exacerbated or non-improved symptoms it would be appropriate on the 2nd call for the child to be conveyed to an assessment facility, such as those listed in 1.3 or an ED.

5.10 Generally all children under the age of 2 will require face to face review by an appropriately trained clinician. If crews consider that the child does not require hospital assessment then this decision should be discussed with the patient's own GP, with OOH, the GP triage service or with a CCC clinician.

5.11 Should this not be possible, thresholds for transporting such children to the nearest

Emergency Department for further assessment should be extremely low.

5.12 If patients have been in contact with a number of health care professionals or services over a period of time, with no apparent resolution or improvement, crews should consider escalation to an assessment facility, such as those listed in 1.3.

5.13 Specialist Practitioners may (where appropriate) consider advising patients that hospital treatment is not necessary. Ambulance clinicians should be cautious with similar advice and make use of GP Triage, unless they have proven specific competence in the area of decision making relative to patient condition.

5.14 General guidelines:

5.15 It is essential that adequate provision is in place for patients who are not conveyed and follow up care / or a treatment pathway is in place. All cases may be discussed with the UCD or CSD clinicians within the CCC, or a GP to discuss the appropriateness of leaving a patient at scene (GP triage). The UCD / CSD clinicians will be able to give advice about the most appropriate pathway and will log details of the outcome against the incident in the CAD.5.15 If a patient is not conveyed then the attending clinician must ensure that the patient is given relevant discharge advice and contact details, should their condition deteriorate. This must include that if there are any new symptoms, or if the condition gets worse, changes or they have any other concerns, to call us back on 111 or 999. This must be clearly documented in the documentation.

5.16 If the attending clinician has any doubt about the patients' condition, then consultation with the GP or OOH should be made to support the non-conveyance (or conveyance decision) to an appropriate healthcare setting.

5.17 A list of conditions that would normally require further Doctor level investigation, diagnostics or assessment can be found in Appendix A. This list is not an exhaustive guide and will be updated via the Operational Directive process and a bi-annual review of this policy.

5.18 If another healthcare professional (such as those listed in 1.3 etc) has advised the patient to make an emergency call and it is subsequently established by the attending clinician that the call is not an emergency that requires transportation to hospital, the original referrer should be contacted so that a mutually agreed plan of action can be made (consider GP Triage). The action plan must be confirmed with the CCC and logged against the incident on the CAD system in case of later enquiry. When the original referrer (such as those listed in 1.3) is no longer available, the EOC should contact the relevant agency informing them of the non-conveyance decision.

5.19 If the ambulance clinician considers that the patient is suitable for GP Triage, then Consultation with the GP or OOH provider should be attempted. If the GP Triage attempt is unsuccessful then the clinician should make the decision whether to convey to an appropriate healthcare setting, such as an ED or those listed in 1.3. For all patients where GP Triage is attempted full documentation must be made. For staff using paper records this should be done on CAS 101/ 102 forms.

5.20 If the attending clinician considers that it may not be safe to leave a patient unattended then the patient should be transported to an appropriate healthcare setting, such as an Emergency Department or MIU / WiC. Such arrangements should be communicated to the CCC, who will record the information on the CAD system.

5.21 It is acceptable for the attending clinician, in consultation with the patient and/or carer, to request an alternative response from the CCC. This may include a Specialist Practitioner, but it must be established that there is no immediate risk to the patient. Only when it is confirmed that an alternative clinician will be able to attend should the SCAS clinician stand down from the incident.

5.22 If an alternative response is required, or the patient is suitable for GP Triage, then the relevant healthcare provider should be contacted, and they should be provided with the clinical findings, history and reasons for the visit / contact request. Incident number and contact details should also be provided for the return call.

5.24 In the event that delays are experienced with the return call, the situation must be discussed with the patient/carer and the communication centre for an action plan to be agreed, as appropriate. (for example: 'welfare checking' via the *CCC clinician* / Clinical Support Desk). Details of such arrangements must be recorded against the incident on the CAD system**.**

5.25 The patient should be given worsening advice and relevant information and contact details should their condition deteriorate. (This must include that if there are any new symptoms, or if the condition gets worse, changes or they have any other concerns, to call back on (111 or 999). When GP Triage is utilised, the communications are directly between the SCAS clinician and the Doctor / OOH clinician.

5.26 When referring a patient to their GP or OOH GP (GP Triage), the downstream clinician will often 'phone the patient instead of visiting or arrange an alternative assessment via district nursing, mental health, domiciliary consultant, admission to nursing home etc. Therefore, the attending ambulance clinician should not promise a GP visit as this is up to the downstream clinician's clinical judgment.

5.27 The GP decision should be clearly documented. Responsibility for patient care is then transferred to the receiving clinician.

5.28 If the attending clinician requests a Specialist Practitioner and then leaves the scene, it is not expected that the Specialist Practitioner will travel under emergency conditions, unless specifically requested by the attending crew. Safety-netting advice must be given to the patient. This must include that if there are any new symptoms, or if the condition gets worse, changes or they have any other concerns, to call back on 111 or 999.

5.29 When an ambulance clinician is called to an address to give assistance to a patient (e.g. a regular call to assist to bed etc) all clinical findings must be documented on the Patient Clinical record. A separate record must be made for each attendance.

5.30 If a decision is reached that the crew will convey a patient to a GP surgery, prior agreement should be reached with the GP practice (GP Triage) and CCC should be

informed that this is the selected pathway

5.31 Any written or verbal advice given to the patient / carer must be recorded on the Patient's Clinical Records. EOC can also be contacted to update the CAD record.

5.32 Patient advice leaflets are available on all frontline vehicles and via the SCAS ePR system.

5.33 If a patient has fallen then the ambulance crew / clinician must satisfy themselves that the patient has not sustained a serious injury and their mobility is the same as their pre-fall presentation, and that there is a low index of suspicion that a fall will re-occur imminently. If this is not the case, then the patient should be referred to an appropriate service or consideration given to a conveyance decision.

5.34 All patients that have sustained a fall aged 65 or over but are uninjured or left at home should be referred to their local falls service, or a suitable Healthcare Professional. This is done by completing a falls referral at the earliest opportunity.

5.35 A social history assessment may include such details as mobility and any aids used, home help, carers, family support and general living environment. These should be documented appropriately and marked as Social History (**abbrev. SHx**). Special consideration should be made for the elderly, mental health patients and people of no fixed abode as these are high risk groups.

5.36 If a Specialist Practitioner arrives at the scene and makes the decision (or makes the decision when backing up a crew) that a patient can be dealt with at the scene, then clinical responsibility is transferred to that individual Specialist Practitioner. The crew should "stand down" from the incident as soon as it is appropriate to do so.

5.37 In the event that crews are using paper records, completed patient report forms should be deposited at the base station at the end of the shift so that they can verified and added to the CARS system.

5.38 If it is necessary to re-attend a patient who has been dealt with by an ambulance clinician in the previous 24 hours (either over the phone or face to face) then staff should ensure that these cases are recorded on the Trust's Incident reporting system, Datix, at the earliest opportunity.

6.0 DEVIATION FROM CLINICAL GUIDELINES

6.1 All staff must adhere to the Trust's approved national and local clinical guidelines.

6.2 The Trust can be notified of deviations from clinical practice in a number of ways, through other healthcare professionals, complaints, claims, peer review, the Freedom to Speak Up Guardian, and incident reporting using the appropriate Trust policy.

6.3 If staff deviate from clinical guidelines, they must inform the Organisation using the Trust's Datix Reporting System.

6.4 The incident will be dealt with as a “clinical incident” under the Trust’s Adverse Incident and Investigation Policy and Procedures and the staff member(s) given the appropriate support as detailed in the policy.

6.5 All clinical incidents will be dealt with in a fair learning culture and, if appropriate, support, guidance and re-training will be offered. If there are concerns following the investigation this would be referred to the Trust Capability Policy. This policy is designed to provide support for staff members in their decision-making.

7.0 OPERATIONAL GUIDANCE REFERENCE PATIENT REFUSES TREATMENT

7.1 **Patients who refuse hospital transport or clinical advice.** Due to the serious litigation risks associated with patients who refuse hospital transport or clinical advice, failing to complete the relevant documentation set out in this policy will be viewed as a serious breach of duty and could result in disciplinary action and/or referral to the clinician’s professional body (e.g., HCPC, NMC or GMC).

7.2 *Patients refusing hospital transport or clinical advice at a private address* should (if possible) be left in the care of a responsible person. The safety advice explained to the responsible person (e.g., patient /relative / friend) must advise that if there are any new symptoms, or if the condition gets worse, changes or they have any other concerns, to call back. If the patient is alone and there is no one available to take responsibility for the patient the crew should attempt to establish the name of the patient’s GP and try to make contact (GP Triage) to discuss the situation and arrange for a GP/Duty Doctor or OOH Doctor to visit if appropriate. Safety advice must be given and documented.

7.3 *Patients refusing hospital transport or clinical advice in a public place* should (where possible) be left with a responsible person. The safety advice explained to the patient/relative/friend etc must include that if there are any new symptoms, or if the condition gets worse, changes or they have any other concerns, to call back.

7.4 Because of their vulnerability crews must exercise extreme caution if the patient is 16 years or under. CCC must always be advised, and if deemed appropriate, the police should be notified. Attempts should be made to contact the parents/guardians, or the school if within school hours. Consider completion of a Safeguarding Referral Form.

7.5 If a patient is deemed not to require medical treatment at a facility (listed in section 1.3) but there is no one willing to accept responsibility and the patient is incapable of leaving the scene unaided or there is concern for the patient’s welfare, then the crew should complete an assessment of the patient’s mental capacity and request the attendance of the police at the scene and await arrival if necessary/possible.

7.6 In very rare cases of the very young, vulnerable or elderly patients, the crew in consultation with the police may decide that transport to the patient’s home is the most appropriate course of action if transportation to an appropriate healthcare facility is not deemed appropriate. This is to be very carefully considered depending on the patient’s home location and current ambulances resources. The operational crew should gain permission to do this from the CCC.

7.7 Where a patient declines treatment or transfer to hospital against the advice of the clinician the following procedures will be followed:

- CSD / UCD: The *CCC clinician* will log all the patient's details and advice given on the incident log on the CAD (Computer Aided Dispatch System).
- Face to Face: all patients should have documentation completed. This will be in ePR format or (for staff using paper records) on a CAS 101/ 102.
- If a patient is under the age of 18, the patient's parent or guardian must be asked to sign the form. If the patient or guardian refuses to sign the relevant form this should be logged with the CCC and recorded in the documentation. If appropriate, then a Safeguarding form should be submitted.
- In the case of a double crewed vehicle both crew members should sign all relevant paperwork.
- All treatment and advice offered should be recorded on the relevant Clinical Patient Record. This will be in ePR format or (for staff using paper records) on a CAS 101/ 102.
- If the patient is in their normal place of residence, then GP Triage should be used.
- These procedures will reduce risk for the patient and the ambulance clinician.

7.8 It is important that any refusal (on the behalf of the patient/carer) to accept advice given to them by a clinician is recorded. In these cases, full documentation should be completed in line with risk management procedures. Also consider contacting CCC to place a note on the CAD. Where a patient requires medical care, but declines transport to hospital, a mental capacity assessment should be performed.

7.9 When the attending clinician deems that the patient requires hospital treatment, but this is refused, the reason behind the clinician's decisions must clearly explained to the patient / carer. GP Triage should then be attempted. Appropriate follow-up care must be given to the patient / carer that includes, clear instructions should the patient's condition worsen.

7.10 Worsening instructions given by the *CCC clinician o*r attending clinician must be recorded on the CAD incident log and in some situations a further 999 call would be appropriate.

7.11 Whenever the patient declines any advice; the advice communicated to the patient is to be documented either by the *CCC clinician* against the incident on the CAD system or on the Patient Clinical Record.

7.12 Whilst a patient may respond positively to treatment and decline hospital treatment there may be underlying reasons why the acute episode occurred e.g., when the patient is not receiving appropriate medication, repeat callers may not be coping with their self-management regimes etc. In such instance's medical advice from the patient's General Practitioner (GP Triage) would be appropriate and the patient/carer should be informed.

7.13 The attending clinician must inform the CCC that the patient has been examined / treated / referred at scene and has refused hospital assessment.

Overdoses (deliberate or accidental):

7.14 Overdoses are a common occurrence which require sympathetic handling by

ambulance clinicians. When clinically assessing a patient, who has taken a deliberate overdose it is important to complete a suicide and self-harm risk assessment in line with the AACE / JRCALC Guidelines (2016) and transport the patient to an appropriate Emergency Department for assessment.

7.15 In addition, an assessment of the patient's mental capacity should also be completed in line with SCAS Mental Capacity Policy. Use of either or both (depending on individual circumstances) of the mental capacity assessment tools should also be considered for patients who have taken an accidental overdose.

7.17 A mental capacity assessment should be completed to guide ambulance as to whether the patient has capacity. This should be completed in all cases where a patient's capacity is in question. This will be in ePR format or (for staff using paper records) on a CAS 150.

7.18 If the patient is conscious and orientated and not reasonably believed to lack mental capacity, every effort should be made to persuade the patient to attend an Emergency Department.

7.19 If the patient adamantly refuses to attend hospital, the crew should request the attendance of the patient's GP (GP Triage) or if appropriate contact mental health crisis team and ascertain if there is an alternative metal health care pathway that can be used. Crews should remain on scene until arrival of GP if called, unless it is clinically safe to leave the patient with a relative/friend until the GP arrives.

7.20 **Poison Information**:

7.21 If the operational crew does not have access to Toxbase, all information regarding drugs or medicines will be obtained through ePR or via the UCD / CSD.

7.22 **Dealing with a patient who has suspected Mental Capacity/Health Issues:**

7.23 Crews should perform a mental capacity assessment to form part of the patients recorded/handover when the patient arrives at the healthcare facility.

7.24 If the patient is believed to have mental capacity issues and adamantly refuses to attend an appropriate Healthcare facility, then the crew should attempt GP Triage and request the attendance of the patient's GP or (if appropriate) contact the mental health crisis team and ascertain if there is an alternative metal health care pathway that can be used. Crews should remain on scene until arrival of GP if called.

7.25 If it is necessary to instigate the Mental Health Act 1983 (revised 2007) crews should ascertain the appropriate time scale for the patient's removal and whether they are required to remain on scene by the health professional present. Operational crews should then inform the CCC and await instructions.

7.26 **Patient refuses Transport on Route.**

7.27 If the patient ether recovers on route or changes their mind and is adamant that he/she wishes to discontinue the journey to the healthcare facility, the attending crew should make every effort to persuade the patient to continue the journey and not leave the vehicle. The crew should explain the reasons why they need to continue the journey and if necessary, assess the patient's mental capacity while doing this.

7.28 If the patient does not have any mental capacity issues, or a non-life-threatening condition and is capable of leaving the vehicle without assistance, then the crew should park the ambulance in a safe location that will allow the patient to find alternative transportation home and they should then complete all relevant paperwork which will include the signature of the patient wherever possible.

7.29 If the patient has any of the following:

- Mental Capacity Issues/Life Threatening Conditions
- Unable to leave the ambulance without assistance
- Attempting to leave a moving vehicle
- Insisting on leaving a vehicle in a rural area/motorway where there are no easy transportation links, and the area is unsafe

Then the crew should halt the vehicle in a safe manner and inform the CCC that a police presence is required. If the patient leaves the vehicle the crew must remain on scene until the police arrive.

7.30 In the case of a patient trying to leave a moving vehicle the attendant should push the emergency strip/button and ensure that the vehicle driver will pull over and stop the vehicle as a matter of urgency. Every effort must be made to dissuade the patient from leaving the vehicle.

7.31 Crews can, in exceptional circumstances, use minimal containment (restraint) to prevent a patient leaving the vehicle if:
The patient is reasonably believed to lack mental capacity and containment is in their best interest and /or the patient is detained under the Mental Health Act 1983 (revised 2007). The following conditions must also apply:

- Containment is necessary to prevent harm to patient/or others
- The containment is proportionate to the risk of likely harm
- The least restrictive method is used for the shortest amount of time.

If the patient's behaviour becomes unmanageable then assistance from the police should be requested urgently.

Note Crews must carry out a dynamic risk assessment when considering using minimal containment, minimising risks to themselves.

7.32 Any use of containment must be recorded in the patients records and staff must ensure that at the receiving healthcare facility the use of containment is passed on to the receiving clinician. A Datix entry must also be submitted at the earliest opportunity.

8.0 MONITORING

8.1 The monitoring of this policy will be through the Patient Safety Group

8.2 The monitoring will be performed by:

- Review of patient's notes linked to CWS (ePR) and CARS
- Review of Non-Conveyance rates and documentation standards
- Review of individual clinician's paperwork and performance
- Review of the number of investigations with regards to deviation from practices.
- A review of complaints, legal claims and Datix entries.

8.3 A Trust wide action plan will be developed and monitored by the Governance Committee for completion.

9.0 OTHER RELATED DOCUMENTS

9.1 South Central Ambulance Service NHS Foundation Trust Adverse Incident and Investigation Policy.

9.2 CSPP 5 SCAS Medicines Management Policy

9.3 CSPP 4 SCAS Patient Clinical Record Policy and Procedure

9.4 South Central Ambulance Service NHS Foundation Trust Patient advice leaflets.

9.5 CSPP 7 SCAS Care Pathway Policy

9.6 GP Triage protocol (SOP)

9.7 GP Triage protocol (SOP) residential and nursing homes

9.8 Capability Policy

9.9 Freedom to Speak Up (Whistle blowing) Policy

9.10 Duty of Candour policy

9.11 AACE / Joint Royal College of Ambulance liaison committee (2016)

9.12 Job Descriptions for Consultant Pre-Hospital Care Practitioner and Specialist Practitioner

9.13 South Central Ambulance Service – Mental Capacity Policy

9.14 Mental Capacity Act Flow Chart

10.0 NOTE TO APPENDICES

THIS POLICY WILL BE SUBJECT TO REVIEW AND MODIFICATION AND THE INFORMATION CONTAINED IN THE FOLLOWING APPENDICES WILL, FROM TIME TO TIME, BE AMENDED AND UP-DATED AS APPROPRIATE.

Purpose of Appendices:

The attached appendices define and describe the individual provision that is made for patients when it may be more appropriate for them to be treated or referred to specialist care individuals / teams / agencies rather than be transported to an Emergency Department.

Scope of Appendices:

The individual treat and refer procedures are applicable to the type/group of patients further described herein. The categories of patient type and care regimes may be expanded from time to time as the principle of Treat and Refer is adopted by other care groups.

APPENDIX A
CONDITIONS THAT SHOULD NORMALLY BE CONVEYED TO HOSPITAL:

1. **AIRWAY Problems**, especially if complaining of throat or mouth swelling in the context of a possible allergic reaction – even if apparently well, these cases can deteriorate over a few hours.

2. **Breathing Problems** – respiratory distress or shortness of breath particularly with a raised respiratory rate, abnormal colour, cyanosis, that is different to the patient's normal state (for example, chronic obstructive pulmonary disease or unable to speak in sentences).

3. **Non- Traumatic Chest Pain -** occurring at rest or during exercise, at any time within the last 24 hours. This includes resolved chest pain. Patients who have symptoms indicative of AMI (i.e. raised ST segments, general clinical presentation and / or chest pain) should be transported to hospital as per locally agreed protocol, with enough time to ensure that PPCI can be performed within the recognised time frames, in accordance to the National Service Framework for Coronary Heart Disease and the Trust Coronary Heart Disease policy and procedures.

4. **Any suspected cardiac conditions**

   Remember the elderly and diabetic patients are high risk groups to have cardiac problems without the associated chest pain. Ensure a high index of suspicion for those that feel unwell, lethargic, and have other cardiac indicators such as palpitations, or ischaemic traces on ECG or abnormal blood pressure.

5. **Any chest pain associated with abnormal physiology** including traumatic chest pain with a suspicion of underlying rib fractures

6. **Acute (usually <24 hours) Confused State** particularly where the person is vulnerable/alone.

7. **Acute anxiety attack / state** where there is a chance that the patient will become endangered. Patients should only be discharged at the scene if there is normalisation

of physiological signs, e.g., heart rate, respiratory rate and blood pressure. The diagnosis of ‘anxiety attack’ or ‘panic attack’ should be used with extreme caution.

8. **Abdominal pain** unless minor or due to a recognised on-going problem e.g.: constipation or urinary tract infection, where an OOH doctor / nurse or Specialist Practitioner (see appendix D) attendance may be more appropriate. Abdominal pain normally requires GP consultation / a full clinical examination and / or observation in hospital.

9. **Symptoms suggestive of a stroke** should be transported to the nearest appropriate treatment centre – for local arrangements please refer to relevant Operational Directives.

10. **Epileptic seizures / Febrile Convulsion** that continue for more than 15 minutes (except in special circumstances and on discussion with carers) or any fit or convulsion if this is the first ever episode.

11. **Undiagnosed cardiac dysrhythmias:** or any dysrhythmia associated with loss of consciousness, chest pain or other complication.

12. **Falls associated with a suspected fracture;** (any patient unable to weight-bear after a fall, who was previously able to walk **MUST** be taken to the ED). Particular caution must be taken with patients with impaired cognitive function, such as dementia.

13. **Falls associated with loss of consciousness** or abnormal pulse/blood pressure/respiratory rate or conscious level.

14. Falls where a patient has been lying on the floor in an immobile state for in excess of 4 hours. These patients are at extreme risk of complications, such as pressure sores, acute kidney injury and rhabdomyolysis.

15. **Severe pain** such as abdominal pain that is severe enough for the person not to be left in such discomfort.

16. **Sudden onset ‘thunderclap’ headaches or unexplained neck pain which may be** indicative of sub-arachnoid / sub-dural bleeding.

17. **Burns - partial thickness / full thickness** any percentage specifically if facial. **Superficial burns** over 1% (i.e. size of patients own hand) but less than 5%– may be dealt with in a Walk in Centre environment.

18. **Patients who are systemically unwell with signs of infection with an elevated National Early Warning Score (NEWS2).** In SCAS crews are encouraged to use the NEWS2 tool, which is available on ePR. Whilst the NEWS2 score does not replace clinical judgement a NEWS2 score of 5 or above is indicative of the need for urgent hospital assessment and treatment.

19. **Symptoms associated with suspected meningitis.** (i.e. non-blanching rash / septicaemia, photophobia / severe headache) The patient should be assessed and treated as per the JRCALC guidelines. Rapid transport to hospital is recommended in these cases.

20. **Inhalation of smoke / fumes** – remember flash burns and house fires can lead to oedema of airways - post event. Patients with Carbon Monoxide poisoning may exhibit normal oxygen saturations. In some cases, the presence of inhaled toxins will not be apparent.

21. **Carbon monoxide / chemical poisoning** – all ambulance staff need to be alert to the presence of potential toxins when attending patients with unexplained symptoms (i.e. flu) or when more than one patient is affected. All pregnant patients with smoke inhalation should be transported to hospital due to foetal vulnerability to carbon monoxide.

22. **Blood pressure** – any patient exhibiting significant hypertension that is currently undiagnosed and untreated. Hypertension that is being treated with medication and still exhibits elevated **Systolic** and /or **Diastolic** measurements should be considered as danger signs for stroke. KYBP guidance is available on line if required.

23. **Head injuries whose condition is impaired by alcohol or drugs**; with any loss of consciousness (LOC); any suspicion of skull fracture; high energy mechanism; any seizure (convulsion or fit) since the injury or focal neurological deficit. Note where the head injury is minor and there is a responsible adult is available to stay with patient (especially the young or elderly) the patient may be suitable for assessment by a Specialist Paramedic / Nurse.

24. All patients on warfarin or other anticoagulant therapy (including the NOVEL anticoagulants but excluding aspirin) should be conveyed to hospital in line with the 2016 NICE guidance for Head Injury.

25. Any patient with a head injury who is being discharged must be given written Head Injury Instructions which are available on all SCAS vehicles and on the ePR devices.

APPENDIX B

South Central Specialist Practitioners (formerly Emergency Care Practitioners)

Inclusion:

Minor illness - South Central Specialist Practitioners can visit a range of minor illness such as (non-exhaustive list):

- Tonsillitis
- Otitis Media (earache)
- Sinusitis
- Chest infection
- Urinary Tract Infection
- Diarrhoea and Vomiting
- Headaches
- Flu symptoms / coughs and colds
- Soft tissue infection
- Conjunctivitis

Treatment of Minor Injuries (as Walk-in-Centre and MIU):

- Sporting injuries – should be considered to undertake upper and lower limb assessments
- Wound assessment and closure – using sutures, glue, staples or steri-strips
- Head wounds with no associated loss of consciousness and none of the 'red flags' in the NICE Head Injury Clinical guidance.
- C –spine clearance – RTC

Male catheterisation and blocked catheter assessment / clearance

All *standard* paramedic / nurse responses to life threatening incidents

Appendix C
CLINICAL INVESTIGATION TOOL

SCAS CLINICAL DECISION TOOL

Important: This tool has been designed to give guidance. It does not replace clinical judgement

Key
- Recommended (white)
- Only if appropriate (black)
- Consider (yellow)

	Pulse	Resp rate	Blood Pressure	Blood Sugar	GCS Assessment	Urinalysis	Temp	O2 Sats	Peak Flow	Peak Flow (post neb)	12 lead ECG	Pain Score	FAST assessment	Blood pressure both arms	Mental Capacity Test	Consider SP	Safeguarding	Limb Observations	C-spine assessment	NEWS2
Abdominal Pain	RECORD FOR ALL PTS	RECORD FOR ALL PTS	RECORD FOR ALL PTS	Recommended	Recommended	Consider	Recommended	Recommended	Only if appropriate	Only if appropriate	Consider	RECORD FOR ALL PTS	Only if appropriate	Consider	Only if appropriate	Consider	Only if appropriate	Only if appropriate	Only if appropriate	CONSIDER FOR ALL PTS
Allergic Reaction				Only if appropriate	Recommended	Only if appropriate	Recommended	Recommended	Recommended	Only if appropriate	Only if appropriate		Only if appropriate	Only if appropriate	Only if appropriate	Consider	Only if appropriate	Only if appropriate	Only if appropriate	
Asthma				Only if appropriate	Recommended	Only if appropriate	Recommended	Recommended	Recommended	Recommended	Only if appropriate		Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	
Back Pain				Only if appropriate	Recommended	Consider	Recommended	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate		Only if appropriate	Consider	Only if appropriate	Consider	Only if appropriate	Only if appropriate	Only if appropriate	
Collapse				Recommended	Recommended	Consider	Recommended	Recommended	Only if appropriate	Only if appropriate	Recommended		Recommended	Consider	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	
Chest Pain (do not delay transport for investigations)				Recommended	Recommended	Only if appropriate	Recommended	Recommended	Only if appropriate	Only if appropriate	Recommended		Only if appropriate	Recommended	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	
Cardiac Arrest (post ROSC)				Recommended	Recommended	Only if appropriate	Recommended	Recommended	Only if appropriate	Only if appropriate	Recommended		Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	
Diabetic Problems				Recommended	Recommended	Consider	Recommended	Recommended	Only if appropriate	Only if appropriate	Only if appropriate		Only if appropriate	Only if appropriate	Only if appropriate	Consider	Only if appropriate	Only if appropriate	Only if appropriate	
Falls				Only if appropriate	Recommended	Consider	Recommended	Recommended	Only if appropriate	Only if appropriate	Consider		Only if appropriate	Only if appropriate	Only if appropriate	Consider	Only if appropriate	Only if appropriate	Consider	
Fits				Recommended	Recommended	Only if appropriate	Recommended	Recommended	Only if appropriate	Only if appropriate	Only if appropriate		Recommended	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	
Fractured Neck of Femur				Only if appropriate	Recommended	Only if appropriate	Recommended	Recommended	Only if appropriate	Only if appropriate	Only if appropriate		Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Recommended	Only if appropriate	
Haemetemesis				Only if appropriate	Recommended	Only if appropriate	Recommended	Recommended	Only if appropriate	Only if appropriate	Only if appropriate		Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	
Headache				Recommended	Recommended	Consider	Recommended	Recommended	Only if appropriate	Only if appropriate	Only if appropriate		Recommended	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	
Head injury (patients on anticoagulants must be conveyed)				Only if appropriate	Recommended	Only if appropriate	Recommended	Recommended	Only if appropriate	Only if appropriate	Only if appropriate		Recommended	Only if appropriate	Only if appropriate	Consider	Only if appropriate	Only if appropriate	Only if appropriate	
Minor Lacerations				Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate		Only if appropriate	Only if appropriate	Only if appropriate	Consider	Only if appropriate	Only if appropriate	Only if appropriate	
Minor RTC				Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate		Only if appropriate	Only if appropriate	Only if appropriate	Consider	Only if appropriate	Only if appropriate	Consider	
Overdose				Only if appropriate	Recommended	Only if appropriate	Only if appropriate	Recommended	Only if appropriate	Only if appropriate	Consider		Only if appropriate	Only if appropriate	Recommended	Only if appropriate	Consider	Only if appropriate	Only if appropriate	
"Panic" Attack / Hyperventillation				Recommended	Recommended	Only if appropriate	Recommended	Recommended	Recommended	Only if appropriate	Consider		Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	
Suspected Sepsis				Recommended	Recommended	Consider	Recommended	Recommended	Only if appropriate	Only if appropriate	Only if appropriate		Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	
Shortness of Breath				Recommended	Recommended	Only if appropriate	Recommended	Recommended	Recommended	Recommended	Consider		Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	
Social Problems (vulnerable / elderly)				Only if appropriate	Recommended	Only if appropriate	Recommended	Recommended	Only if appropriate	Only if appropriate	Only if appropriate		Only if appropriate	Only if appropriate	Consider	Only if appropriate	Recommended	Only if appropriate	Only if appropriate	
Stroke (do not delay transport for investigations)				Recommended	Recommended	Only if appropriate	Recommended	Recommended	Only if appropriate	Only if appropriate	Only if appropriate		Recommended	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	Only if appropriate	

SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

APPENDIX D
STANDARD OPERATING PROCEDURE CLINICAL VALIDATION PROCESS

Version:3
Approved by Executive Team / Clinical Review Group
Directorate: Clinical

1. INTRODUCTION

1.1 This guideline aims to support.

- All Newly Qualified Paramedics (NQP), Ambulance Technicians (AT) and Associate Ambulance Practitioners (AAP) whilst working as the lead clinician.
- All relevant staff in understanding the scope of practice of any clinicians below the level of Band 6.

1.2 The NQP/AT/AAP will be expected to operate within Trust policies and guidelines as well as adhering to National standards of practice and procedure.

1.3 The NQP/AT/AAP will be expected to seek advice from, or refer to, a more senior clinical colleague when a decision to deviate is necessary.

2. DEVIATIONS

2.1 In the context of this guideline a deviation can be defined as any departure from a pre-existing set of instructions, protocol or expected standard of care.

2.2 It is accepted that there will be occasions when it is not possible to comply fully with accepted clinical guidelines and/or protocols. In these circumstances all staff must to be able to justify and document any such deviations.

3. CLINICAL GUIDELINES

3.1 Clinical Guidelines include, but are not restricted to, those provided by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC[1]), the National Institute for Health and Clinical Excellence (NICE[2]), the British Thoracic Society[3], The Resuscitation Council (UK)[4] and internal Trust Clinical Guidelines[5].

3.2 NQP/AT/AAP must not deviate from clinical guidance when discharging the patient at scene, without either a senior band 6 clinician, or another appropriate Healthcare Professional (senior or specialist) validating their decision.

3.3 If the intention is to **convey the patient** and a deviation is required, NQP/AT/AAP must document the deviation and the rationale as to why the deviation was required on the Electronic Patient Record (ePR). With the exception of existing requirements within Trust documents, NQP/AT/AAP do not have to request senior clinical advice unless it is felt that additional support is required.

3.4 The Trust's Clinical Guidelines can be found on the Trust intranet site.

4. STANDARD OPERATING PROCEDURES

4.1 Within the Trust there are a number of clinical and medicine related directives, as well as directives not directly relating to patient care.

4.2 NQP/AT/AAPs must adhere to all Clinical and Medicine Directives.

4.3 The Trust's SOPs can be found on the Trust intranet site.

5. MEDICINES

5.1 NQP/AT/AAPs can administer medicines in accordance with Trust guidelines and protocols. If an NQP/AT/AAP wishes to administer these specific medicines outside Trust guidance, then advice must be sought from a Doctor.

5.2 Paramedics cannot deviate from a Patient Group Direction.

5.3 The Trusts Patient Group Directions and Medicine Protocols can be found on the Trust intranet site.

6. CONVEYING THE PATIENT TO DEFINITIVE CARE

6.1 When conveying the patient to hospital or healthcare facility, NQP/AT/AAPs will not be expected to contact senior clinical advice unless a deviation is felt that additional support is needed.

6.2 It is implicit that when considering a deviation, all clinicians understand the clinical, physical, procedural and legal implications (i.e. consent, best practice and competence) of deviating from agreed guidelines and protocols in the circumstances with which they are faced.

7.0 DISCHARGE FROM SCENE

7.1 When considering discharge at scene, clinical advice will need to be sought when **any** of the following are present:

- The patient has signs of infection.
- Deviation from clinical guidance or protocol is required.
- Patient is in a high-risk group*.

*Details of what constitutes a high-risk group can be found below.

7.2 The decision to discharge at scene for patients falling within the above groups must be made in agreement with the Clinical Validation Line (CVL) which will be managed by clinicians based at the CVL during office hours and by CSD at all other times. Other modes of validation are still valid and the CVL is not meant to replace any existing routes and are detailed more in Table 1. In cases where an agreement cannot be reached, the final decision will lie with the clinician conducting the validation process.

7.3 Patients who are deemed stable and do not sit within a high-risk group can be discharged without seeking further clinical advice.

7.4 To help validate NQP/AT/AAP's decision to discharge a patient at scene, a clinical decision support tool has been produced (Appendix A).

7.5 Advice can be obtained from a number of sources, which will often depend on the type of advice required. Table 1 highlights some examples.

7.6 Table 1 – Examples of sources of advice and support

Source	**Type of advice**
Clinical Validation Line (CVL)	Decision support when considering discharge at scene or referral to an alternative pathway **(mandatory for NQP/AT/AAP when dealing with pre-determined high risk patient groups).** Deviations from clinical guidance and SOPs. Decision support when considering interventions Local clinical pathway information
Any Band 6 or above Clinician	• Supportive face to face validation from crew mate or any B6 or above clinician attending any incident
General Practitioners/HCP within Healthcare Practice/OOH	Chronic/long term condition advice Current medication/treatment Recent HCP contact Care plan information Advance decision/DNAR/TEP information GP follow up requests.
Minor Injury Units	• Advice on patients who could be taken to their department.
Emergency Departments	• Advice on patients who could be taken to their department.

8. REQUESTING CLINICAL ADVICE

8.1 To request advice regarding a decision to non-covey, the clinician on scene will be required to call the CVL via their vehicle phone/handheld radio set on **01844 398086**. This will be answered by a clinician in on the Urgent Care Desk between 0600 and 0200 and calls between 0200-0600 will go through to NEOC/SEOC CSD and then each case can be discussed.

8.2 If a clinician is not immediately available via the CVL the NQP/AT/AAP will hear a recorded message asking them to text a message to **07388 857576** and ask for a call back.

8.3 If the clinician on scene hasn't received a call back within 20 mins then validation should be sought from GP either in hours or out of hours.

8.4 IF the NQP/AT/AAP is unable to access validation via by any means then the decision should be to transport to the nearest appropriate healthcare facility.

8.5 If clinical advice has been provided from the CVL or an alternative source, it is imperative that the NQP/TA/AAP highlight who provided the advice, what advice was given and any details of ongoing care and safety netting.

8.6 It is imperative that when seeking clinical validation, a recorded line is used to capture the advice given.

8.7 Once Clinical Validation is complete, the ePR should be updated by the NQP/TA/AAP with the relevant information, advice and decision made.

9.0 PROVIDING CLINICAL ADVICE

9.1 Clinical Validation

9.1.1 Clinicians operating on the CVL should be able to log into the SCAS network and be to access iCAD and desktop ePR.

9.1.2 On receiving a call for validation, the CVL must review the assessment with the clinician on scene to discuss further. Clinicians will use the Validators Guidance document provided to ensure that the NQP/TA/AAP making the validation request has considered all potential red flags in getting to the final disposition of non –conveyance.

9.1.3 Any advice provided must be recorded into the notes section of iCAD. The clinician on scene will update the ePR following agreement on the treatment and outcome.

10.0 HIGH RISK PATIENT GROUPS

10.1 When treating a patient in a high-risk group, clinical advice must be sought before **discharging the patient at scene**. This is to help mitigate the less obvious risks associated with the patient, which are outlined below.

10.2 Children Under 2

10.2.1 The assessment of children under two is potentially complex and children should not simply be viewed as ‘little adults’. There are many pitfalls for the unwary and inexperienced and they can present healthcare providers with significant challenges wherever the setting, therefore, early recognition of the serious ill / unwell child is vitally important in preventing further deterioration

10.2.2 Children display important differences in their anatomy and physiology and the ways in which conditions present, develop and progress. They may also present with normal physiology early in their illness and risk being misdiagnosed due to the presentation of relatively innocent features.

10.2.3 For more information in the management of paediatrics please refer to Clinical Directive 62.

10.3 Older Patients (over 75)

10.3.1 A significant percentage of our patients are over 75 and present with complex long-term conditions with polypharmacy, making them a challenging group to treat, especially when attempting to discharge the patient at scene. Seek senior clinical advice when considering non-conveyance in patients who are over 75 with any of the following:

- More than 2 long term conditions
- Any history of dementia (or diseases affecting cognitive function) and/or Parkinson's Disease
- Underlying infection (consider sepsis)
- History of traumatic injury
- Medications administered by ambulance clinician

10.4 Head Injuries

10.4.1 Head injuries can present in two stages. Primary injury occurs at the time of injury and may present with physical signs and symptoms, with secondary injury occurring sometime after (often hours or even days later), due to cerebral haemorrhage. Early neurological signs and symptoms may be very subtle; therefore, contact the CVL to discuss the history of the fall and any high-risk factors is advised, when considering non-conveyance. This is particularly relevant to, and has a higher incidence in, our older patient groups.

10.4.2 For more information on the management of head injuries please refer to Clinical Memo 99 and CSPP No. 7.

10.5 Known recent contact with a Healthcare Professional (24 hours)

10.5.1 It has been identified through adverse incidents that clinicians have associated a recent contact with a healthcare professional as a safeguard to future care, e.g. the GP saw this patient yesterday and wasn't concerned, and therefore todays contact is probably less urgent. This should not be assumed and instead a higher index of suspicion should be adopted, as the re-contact will often mean the patient feels no better or has deteriorated. (Recent contact can be defined as contact within the past 24 hours)

10.5.2 For more information please refer to CSPP No7 with further guidance in Clinical Memo 105.

10.6 Mental Health Related Crisis

10.6.1 Patients who present with a mental health crisis can often be complex (particularly in the OOH period) due to the assessment of capacity and consent when considering discharge at scene. Liaison with a more senior clinician will help ensure thought has been given to ongoing risks and help appropriately safety net the patient.

10.6.2 For more information in mental health and mental capacity please refer to CSPP No. 16 and CSPP No.7.

10.7 Maternity Related Presentations

10.7.1 The assessment and management of the pregnant woman can be problematic as

changes occur to the mother's physiology throughout the pregnancy. The compensatory mechanisms which adjust to support development of the baby will result in a change in the 'normal values' of baseline observations and may mislead the clinician into believing the patient is well, when in reality there could be underlying concerns.

10.7.2 There are a number of symptoms which when observed in the non-pregnant person may not be an indication of abnormality but may flag a concern in the pregnant woman. These indications should not be ignored and appropriate referral to specialist local services may be required.

10.7.3 It is also impossible to monitor the baby effectively out of hospital. If the mother reports any reduction of foetal movement or any change in how the baby 'feels' normally should prompt a discussion with a senior clinician, to ensure risk to the baby is minimised and appropriate referral to specialist services are made.

10.7.4 For further guidance refer to CSPP No. 7.

10.8 Safeguarding Concerns

10.8.1 If clinicians attend an incident where they are concerns about an adult or child at risk, contact with the CVL should be made or with the safeguarding team in office hours, especially when the patient may be discharged at scene.

10.8.2 When deciding to discharge at scene, consideration must also be given to how capable, at that moment in time, the parent/carer is at meeting that child's/patient's needs.

10.8.3 Despite there not being a definitive clinical need to convey, a safeguarding concern may necessitate it when there is no other alternative

10.8.4 For further guidance, refer to CSPP No. 1

10.9 C-spine clearance in patients over the age of 65.

10.9.1 Patients over the age of 65 who present with neck pain even after minor trauma, should be considered at high risk of having a c-spine injury.

10.9.2 For additional guidance, refer to Clinical Memo 116.

10.10 Transient Loss of Consciousness (TLoC)

10.10.1 NICE guidelines suggest that the diagnosis of the underlying cause of TLoC is often inaccurate, inefficient and delayed. There is huge variation in the management of TLoC and a lack of a clear pathway may contribute to misdiagnosis and inappropriate treatment. When dealing with a patient who has experienced a TLoC further advice should be sought from the CVL when considering non-conveyance.

10.11 Signs of Infection/ Early Warning Signs of Sepsis

10.11.1

Sepsis is defined as systemic inflammatory response syndrome (SIRS) associated with an infection that is associated with a high morbidity and mortality if unrecognised and not treated promptly. It is estimated that approximately 38,000 patients die every

year due to sepsis.
Not every patient with life threatening sepsis has a fever at the time of initial clinical assessment (some very ill patients may have a reduced core temperature), although the majority will have had a prior history suggestive of a febrile illness.

Early recognition of life threatening sepsis enables the Ambulance Service to initiate life-saving therapy, issue a pre-arrival alert to the receiving Emergency Department to the impending arrival of septic patients, and to trigger the activation of Surviving Sepsis Clinical Care Pathway UPON ARRIVAL at the Emergency Department - which has been demonstrated to significantly improve patient survival.

10.11.2

For further information refer to SCAS Clinical Memo 105 and the Adult and Paediatric Screening tools

11.0 SAFETY NETTING

11.1 Patients who are discharged on-scene must be given advice on what to do and who to contact should their condition deteriorate or fail to improve as anticipated.

12.0 DOCUMENTATION

12.1 An electronic Patient Record (ePR) must be completed for all incidents attended. The record must be completed in accordance with Policy.

12.2 The Clinical Validation tab (pictured above in section 8.1) must also be completed in full. For NQP/AT/AAP this will allow for review and assessment as they progress through the 24-month period.

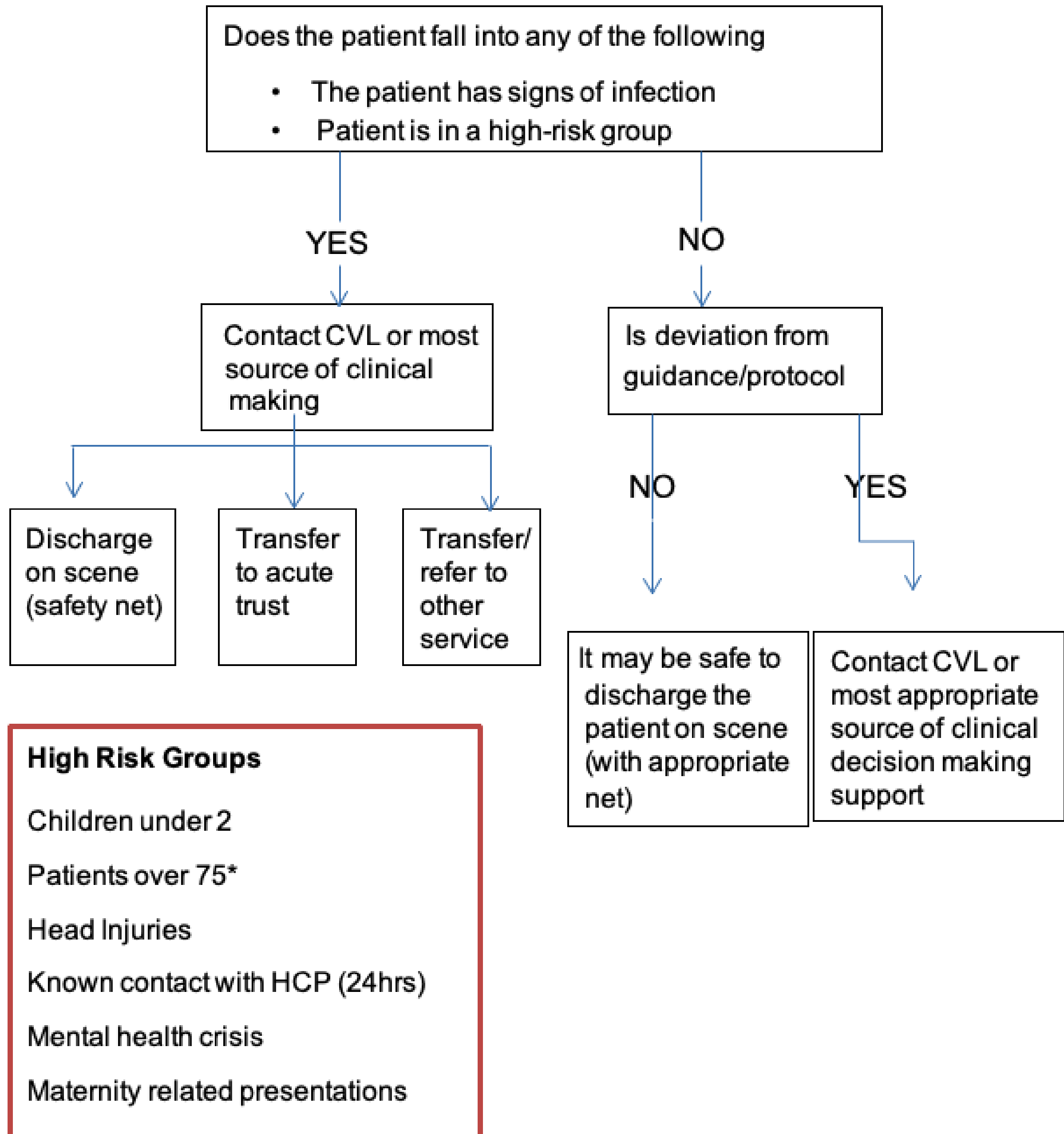
12.3 According to locally agreed protocols, every effort should be made to share information with the patient’s GP, relevant healthcare professionals or other agencies in accordance with the data protection act (insert date), the Trust’s safeguarding responsibilities and the patient’s best interest.

12.4 An appropriate falls referral must also be completed for all patients aged 65 who have suffered a fall and are discharged at scene.

REFERENCES

1. Joint Royal Colleges Ambulance Liaison Committee (2006) Clinical Practice Guidelines. JRCALC.
2. National Institute for Health and Clinical Excellence http://www.nice.org.uk
3. British Thoracic Society standards of care: https://www.britthoracic.org.uk/standards-of-care/
4. Resuscitation Council (UK) https://www.resus.org.uk
5. Department for Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice.

APPENDIX E: FLOWCHART
Decision tool to support the non-conveyance and referral of patients by NQPs



*Patients who are over 75 and have one or more of the following: more than 2 long-term conditions, any history of dementia (or disease affecting cognitive function) and/or Parkinson's disease, underlying infection (consider sepsis), history of traumatic injury, medications administered by ambulance clinician.

APPENDIX F
CLINICAL VALIDATION AMENDMENTS

What does this and Temporary Registration mean and how will this affect my practice?

In 2016 paramedics were differentiated into Newly Qualified (NQP Band 5) and Experience (Band 6) following a review of the national job description. NQP have a period of up to 24 months during which they have consolidation of learning and additional Patient Clinical validation. These groups have been identified below.

Due to Covid 19 Virus a new grade of Paramedic called **Temporary or Proxy NQP (TNQP)** has been introduced by the Health Care Professions Council (HCPC).
They are Student Paramedics working in final 6 months of the course but prior to HCPC Registration. For ease this worker will be called TNQP and will be subject to increased Clinical Validation. Therefore, TNQPs must seek additional Clinical Validation should they wish to discharge the patients in the table.

Whilst it is acknowledged that we would not normally deploy Temporary Paramedics ahead of registration, these Graduate staff have often trained for over two years, have much experience, undertaken hundreds of hours or placements and everyone on the Temporary register will have volunteered to register early to help their NHS.

We are working in unpresented times and this procedure seeks to address the perceived risks of early Temporary Registration.

Original Procedure	Temporary Procedure
Standard NQP Clinical Validation Risk group	**Temporary Registered NQP Clinical Validation Risk Group**
Under 2's	Under 5s
Over 75's who fall into high risk groups (see below flow chart)	Over 60's who fall into high risk groups (see below flow chart)
Over 65 C Spine clearance	Over 50 year C Spine clearance
Mental Health crisis	Mental Health crisis
Safeguarding issues	Safeguarding issues
Maternity related problems	Maternity related problems
Head injuries	Head injuries
Known or recent contact with another HCP	Contact with another HCP with the last 5 days
Transient Loss of Conscious. **NB**: this is to include all events of TLoC regardless of patient presentation,	Transient Loss of Conscious. **NB**: this is to include all events of TLoC regardless of
e.g. Vaso-Vagal, Seizures and Hypoglycaemia.	patient presentation, e.g. Vaso-Vagal, Seizures and Hypoglycaemia.
Any signs of sepsis that could lead to sepsis	Any signs of infection that could lead to sepsis
	Any over 50 years patient who has fallen greater than 1.3 metres regardless of injury
	Any roll over RTC and RTCs estimated over 50 MPH including combined impacts regardless of injury
	Gynaecological related problems
	Palliative care patients

High Risk Patient Groups Requiring Clinical Validation Procedure

- For patients over 75 Years (60 years for TNQPs) and have the following More than two long-term conditions
- Any history of Dementia (or disease affecting cognitive functions) and/or Parkinson's disease Underlying Infection (consider sepsis)
- Any patient who has received chemotherapy in the last 6 weeks History of Trauma
- Any patient prescribed anticoagulant medication
- Any medicine administered by ambulance clinician

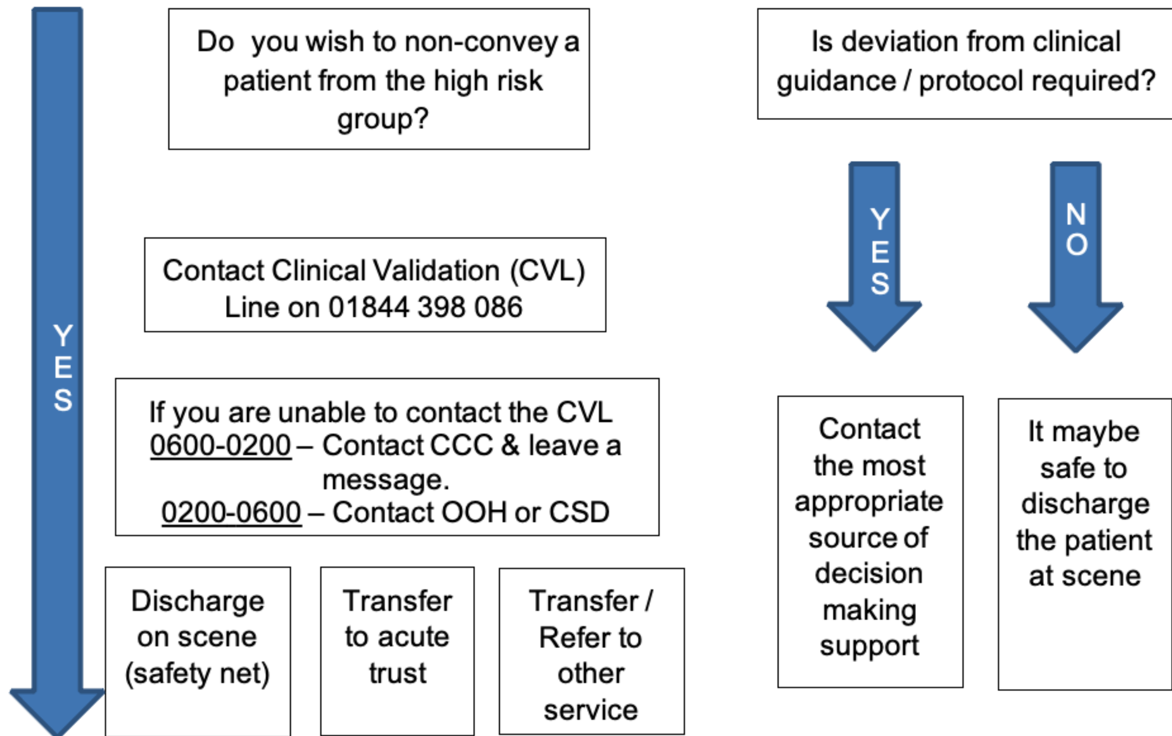
For Newly Qualified Paramedics (NQP), Associate Ambulance Practitioners (AAP), Ambulance Technicians (AT) must use the original procedure. Temporary Newly Qualified Paramedics (TNQPs) attending any patient from the risk groups and wishing to non-convey their patient will need to seek clinical validation from a senior clinician. Validation should be sought in the first instance via the Clinical Validation Line (CVL) from the Urgent Care Desk on 01844 398086 (Text: 07388 857576), GP/OOH or CSD if the first 2 options are not available.

The CVL will be staffed by specialist practitioners and will provide the back up when making decisions in isolation. The CVL is not meant to take away the ability of staff to make complex decisions but to ensure the decision is supported by a senior clinician.

Dr Simon Brown
Acting Medical Director
South Central Ambulance Service

Ian Teague
Assistant Director of Education
South Central Ambulance Service

APPENDIX G
Clinical Validation Process for NQPs, ATs, AAPs & Temp NQPs



Risk Groups for Temp NQP validation

- Children under 5 yrs.
- Patient over 60 yrs.*
- Head Injuries
- Known contact with HCP in last 5 days
- Mental Health Crisis
- Maternity related presentations
- Safeguarding concerns
- C-Spine clearance (greater than 50 yrs.)
- Transient Loss of Consciousness
- Signs of Sepsis
- Palliative Patients
- Gynaecological problems
- Any over 50 years patient who has fallen greater than 1.3 metres regardless of injury
- Any roll over RTC or RTC estimated over 50 MPH including combined impacts regardless of injury

Risk Groups for Standard validation

- Children under 2 yrs.
- Patient over 75 yrs.*
- Head Injuries
- Known contact with HCP in last 24 hours
- Mental Health Crisis
- Maternity related presentations
- Safeguarding concerns
- C-Spine clearance (greater than 65 yrs.)
- Transient Loss of Consciousness
- Signs of Sepsis

All NQP / AT / AAP must validate all patients

High risk patient groups requiring Clinical Validation Procedure

*For patients over 75 Years (60 years for TNQPs) and have the following

- More than two long-term conditions
- Any history of Dementia (or disease affecting cognitive functions) and/or Parkinson's disease • Underlying Infection (consider sepsis)
- Any patient who has received chemotherapy in the last 6 weeks
- History of Trauma
- Prescribed any anticoagulant medication
- Any medicine administered by ambulance clinician

APPENDIX H

1.0 Standard Operating Procedure: Temporary Newly Qualified Paramedic

1.1 This Standard Operating Procedure (SOP) aims to support Newly Qualified Paramedics (NQPs), Ambulance Technicians (AT) and Assistant Ambulance Practitioners (AAPs) and the new role of Temporary Newly Qualified Paramedic (TNQP).

1.2 Clinicians are expected to operate within Trust and national clinical guidelines, policies, and Standard Operating Procedures (SOPs), and seek advice from, or refer to, a more senior clinical colleague when a decision to deviate is necessary.

1.3 NQPs TNQPs will be required to seek Clinical Validation for a period of 24 months.

1.4 Ambulance Technicians and Associate Ambulance Practitioners must always use the Clinical Validation process.

2.0 DEVIATIONS

2.1 In the context of this SOP a deviation can be defined as any departure from a pre-existing set of instructions, guideline or expected standard of care.

3.0 CLINICAL GUIDELINES

3.1 Clinical Guidelines include all those available through the Clinical App published by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC1), and the Trust.

3.2 Student Paramedics, NQPs, ATs, AAPs and TNQP must not deviate from clinical guidance when discharging the patient at scene, without either a Specialist Paramedic / Nurse (Band 7), or another appropriate senior Healthcare professional (Band 6 or above) validating their decision.

3.3 If the intention is to convey the patient and a deviation occurs, you must document the deviation and the rationale as to why the deviation was required on the **electronic Patient Clinical Record** (ePCR). With the exception of existing requirements within Trust documents to do so, you do not have to contact senior clinical advice; unless you feel you require additional support.

4.0 STANDARD OPERATING PROCEDURES

4.1 Within the Trust there are a number of clinical and medicine related SOPs, as well as SOPs not directly relating to patient care.

4.2 No staff may deviate from mandatory (colour coded red) documents under any circumstances. Deviation from amber/green coded clinical or medicine related SOP is permissible only after seeking advice from either a Specialist Paramedic/Nurse (Band 7), or another appropriate Senior Healthcare professional (Band 7 or above).

5.0 MEDICINES

5.1 If an NQP, AT, AAP or TNQP wishes to administer a medicine outside of JRCALC/Trust guidance, advice must be sought from a senior clinician (MIA) prior to administration. All such requests must be discussed in the first instance using the Clinical Validation line.

5.2 It is not legally possible for any Paramedic or Nurse to deviate from a Patient Group Direction (unless operating as a prescriber). In the rare instance that such a deviation is clinically required; a verbal direction of care must be obtained from an independent prescriber. All such request must be discussed in the first instance using the Clinical Validation line.

6.0 CONVEYING THE PATIENT TO DEFINITIVE CARE

6.1 When conveying the patient to hospital or other healthcare facility (e.g., MIU, Community Hospital, and mental health facility) ECAs, Student Paramedics, NQPs, ATs, AAPs and TNQP will not be expected to contact senior clinical advice. Advice may of course still be accessed if required. **Government advice during COVID may change this element.**

6.2 With the exception of the administration of medicines, if the clinician does not deviate from clinical guidelines or protocols, there is no requirement to routinely contact senior clinical advice. However, this should occur if you require clinical support in making the decision to deviate.

6.3 Conveyance does not however allow clinicians to deviate without first considering the degree of deviation e.g. it will not be permissible to administer drugs outside of the scope of a PGD without the authorisation of the Trust.

6.4 It is implicit that when considering a deviation, the clinician understands the clinical, physical, procedural and legal implications (i.e. consent, best practice and competence) of deviating from agreed guidelines and protocols in the circumstances with which they are faced.

7.0 APPROPRIATE NON-CONVEYANCE

7.1 When working as part of a double crewed ambulance crew, should a ECA/Student Paramedic deem that a patient may not require conveyance, they must discuss the case with a Clinical Validator. **This applies to all patients where non-conveyance is considered**. The validation process detailed in flow chart must be used. Patients may only remain on scene once a senior clinician confirms that they support the decision.

7.2 Ambulance Technicians/AAPs must use Clinical Validation when **discharging any patient on-scene in the Standard Risk and High Risk of the flow chart.** The validation process detailed in section 10 must be used. Patients may only remain on-scene once a senior clinician confirms that they support the decision.

7.3 TNQPs must use Clinical Validation **Temp TNQP Risk and High Risk of the flow chart**

7.4 The decision to discharge at scene must be made in agreement with the clinical validator. In cases where an agreement cannot be reached, the final decision will lie with the clinical validator.

7.5 All staff must not discharge patients (who are in the Risk & High criteria) detailed in flow chart without seeking further clinical advice.

8.0 RISK AND HIGH-RISK PATIENT GROUPS

8.1 Children Under 1 (JRCALC, CG26, CG39 & CG42)

8.1.1 All NQPs ATs / AAPs and TNQPs must adhere to Assessment and Management of Children under 2 years of age (5 years for TNQPs).

8.1.2 The assessment of children, especially under one year of age, is potentially complex and children should not simply be viewed as ‘little adults. There are many pitfalls for the unwary and inexperienced and they can present healthcare providers with significant challenges wherever the setting.

8.1.3 Children display important differences in their anatomy and physiology and the ways in which conditions present, develop and progress. They may also present with normal physiology early in their illness and risk being misdiagnosed due to the presentation of relatively innocent features.

8.1.4 For more information in the management of paediatrics please refer to the appropriate Trust Clinical Guidelines and JRCALC app. Bronchiolitis & Croup. Bruising and Injuries in Non-Mobile Children: Assessment, Management and Referral.

8.2 Older Patients (over 75)

8.2.1 A significant percentage of our patients are over 75 (60 years for TNQPs) and present with complex long-term conditions with polypharmacy, making them a challenging group to treat, especially when attempting to discharge the patient at scene. Seek senior clinical advice when treating patients who are over 75 (60 Years for TNQPs) with any of the following:

- More than 2 long term conditions
- Underlying infection (consider sepsis)
- History of traumatic injury
- Any history of dementia or disease effecting cognitive function and/or Parkinson’s disease
- Any patient who has received chemotherapy in the previous 6 weeks
- Any patient who is prescribed any anticoagulant
- Medications administered by ambulance clinician

8.3 Head Injuries (JRCALC)

8.3.1 Head injuries can present in two stages. Primary injury occurs at the time of injury and may present with physical signs and symptoms, with secondary injury occurring sometime after (often hours), due to cerebral haemorrhage. Early neurological signs and symptoms may be very subtle; therefore, contact with the Clinical Validator to discuss the history of the fall and any high-risk factors is advised. This is particularly relevant to, and has a higher incidence in, our older patient groups.

8.3.2 For more information on the management of head injuries and C-Spine please refer to SCAS Clinical Guidelines

8.4 Recent Contact with a Healthcare Professional within 24 hours (5 days TNQP)

8.4.1 It has been identified through adverse incidents that clinicians have associated a recent contact with a healthcare professional as a safeguard to future care, e.g. the GP saw this patient yesterday and wasn’t concerned, and therefore today’s contact is probably less urgent. This should not be assumed and instead a higher index of suspicion should be adopted, as the re-contact will often mean the patient feels no better or has

deteriorated. Recent contact can be defined as contact within the past 24/72 hours).

8.5 Mental Health Related Crisis (JRCALC)

8.5.1 Patients who present with a mental health crisis can often be complex (particularly in the OOH period) due to the assessment of capacity and consent when considering discharge at scene. Liaison with a more senior clinician will help ensure thought has been given to ongoing risks and help appropriately safety net the patient.

8.6 Maternity Related Presentations (JRCALC)

8.6.1 The assessment and management of the pregnant woman can be problematic as changes occur to the mother's physiology throughout the pregnancy. The compensatory mechanisms which adjust to support development of the baby will result in a change in the 'normal values' of baseline observations and may mislead the clinician into believing the patient is well, when in reality there could be underlying concerns.

8.6.2 There are a number of symptoms which when observed in the non-pregnant person may not be an indication of abnormality but may flag a concern in the pregnant woman. These indications should not be ignored and appropriate referral to specialist local services may be required.

8.6.3 It is also impossible to monitor the baby effectively out of hospital. If the mother reports any reduction of foetal movement or any change in how the baby 'feels' normally should prompt a discussion with a senior clinician, to ensure risk to the baby is minimised and appropriate referral to specialist services are made.

8.7 Safeguarding Concerns (JRCALC)

8.7.1 If clinicians attend an incident where they are concerns about an adult or child at risk, contact with the Clinical Validator should be made or with the safeguarding team in office hours, especially when the patient may be discharged at scene.

8.7.2 When deciding to discharge at scene, consideration must also be given to how capable, at that moment in time, is the parent/career at meeting that child's needs.

8.7.3 Despite there not being a definitive clinical need to convey, a safeguarding concern may necessitate it when there is no other alternative.

9.0 REQUESTING CLINICAL ADVICE

9.1 To request advice from the Clinical Validator in the CCC, the clinician on scene will be required to complete basic ATMIST information and other information.

9.2 The Clinical Validator advice will be documented on the ePCR by the on-scene clinician

9.3 If clinical advice has been provided from an alternative source it is imperative that the clinician on scene completes the ePCR, highlighting who provided the advice, what advice was given and any details of ongoing care and safety netting.

9.4 It is imperative that the recorded line is used to capture the advice given (please refer to Trust guidelines for further information on telephone advice and how to use the recorded line).

9.5 It is important to remember that once Clinical Validation is complete, the Primary Survey > Intended Destination data fields are updated to your final outcome e.g. non-conveyance or destination hospital if conveying.

9.6 If you do not receive a confirmatory text reply within 10 minutes of your text to 07388 857576 giving an estimated call back time please contact your area dispatcher to confirm availability of a UCD clinician.

9.7 There will be the rare occasions where you may decide to leave scene prior to receiving Clinical Validation. However, this must be avoided if possible. Acceptable reasons include responding to a General Broadcast for a Cat 1 or if the patient wants you to leave (for the latter, remain outside the property in case the Validator requires further information). Do not return to station to wait for Clinical Validation.

9.8 In addition to validation, a range of advice is available from other sources, as summarised in Table 1. If advice is provided by an external HCP or other external agency, the NQP, AT, AAP or TNQP must still contact a Clinical Validator to validate the decision. The NQP, AAP, AT and TNQP must then complete the clinical validation tab in all cases.

9.9 Examples of Sources of Advice and Support

Clinical Validation Line

- Decision support when considering discharge at scene or referral to an alternative pathway.
- Deviations from clinical guidance and SOPs.

Specialist Paramedic/Nurses

- Decision support when considering discharge at scene or referral to an alternative pathway.
- Decision support when considering treatment/intervention.
- Deviations from clinical guidance and SOPs.
- Local clinical pathway information.

General Practitioners

- Chronic/long term condition advice.
- Current medication/treatment.
- Recent HCP contact.
- Care plan information.
- Advance decision/DNAR/TEP information.
- GP follow up requests

Minor Injury Units

- Advice on patients who could be taken to their department.

Emergency Departments

- Advice on patients who could be taken to their department.

On call Medical Advisor (accessed by requesting a call back via CCC}

- Senior advice on complex decision making, where other sources of advice have not addressed the issue. With the exception of terminating a cardiac arrest, it is not

envisaged that the SCA would be the first contact for advice.
- Trauma care pathways final decision making (as detailed in CG24).
- Medicines and medication legislation.
- Challenging clinical cases.
- Clinical adverse incidents.
- Medication errors.
- Infection control.
- Clinical issues arising between the Trust and other organisations including hospitals and commission groups (excluding hospital handover delays).
- Cessation of Cardiac Arrest outside of guidance.

10.0 Remote Clinical Validation

In periods of high demand routine calls to the UCD may face a delay, please use the Text number to leave a message if unable to get through to the UCD directly, you will receive a call back as soon as possible. You can also request a call via your Dispatch desk who can pass a message to the UCD. In times of exceptional demand, the Trust escalation policy may deem that alternative options can be used, and these will be advised on the day for the minimal time required. All operational clinical staff will be advised via dispatch/MDT message of any additional CVL options. Please remember all CVL calls must be made over a recorded line.

If not dialling the CCC please use the telephone option on your radio which will record the call.

11.0 SAFETY NETTING

11.1 Patients who remain on-scene must be given advice on what to do and who to contact if their condition should deteriorate or not improve as anticipated. This advice must include the standard '*Looking after yourself*' patient advice leaflet.

12.0 DOCUMENTATION

12.1 An electronic Patient Clinical Record (ePCR) must be completed for all incidents attended. The record must be completed in accordance with the Patient Records Policy.

12.2 NQPs and TNQPs will have a review and assessment of documentation as you progress through your training period.

12.3 According to locally agreed protocols, every effort should be made to share information with the patient's GP, relevant healthcare professionals or other agencies in accordance with the Data Protection Act, the Trust's safeguarding responsibilities and the patient's best interest.

12.4 An appropriate falls referral (where local mechanisms exist) must also be completed for all patients aged 65 or over who have suffered a fall, irrespective of whether they are transported to hospital.