



# **CLINICAL SERVICES POLICY & PROCEDURE (CSPP NO. 7)**

## **CARE PATHWAY POLICY AND PROCEDURES**

**July 2022**

**TABLE OF CONTENTS**

- DOCUMENT INFORMATION .....3
- 1. Purpose.....4
- 2. Scope .....5
- 3. Equality statement .....5
- 4. Roles and responsibilities.....6
- 5. Care Pathway Procedure: Clinical Support Desk .....8
- 6. Care Pathway Procedure: Operational Patient Facing Staff .....11
- 7. Deviation from clinical guidelines .....15
- 8. Operational Guidance Reference Patient Refuses Treatment.....16
- 9. Monitoring .....20
- 10. Other related documents .....20
- 11. Note to appendices .....21
- 12. Appendix A: .....22
- 13. Appendix B: .....25
- 14. Appendix C:.....26

## **DOCUMENT INFORMATION**

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## 1. 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 the 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 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. Scope**

- 2.1 This policy applies to all SCAS clinical staff, including Clinical Support Desk clinicians triaging public emergency 999 calls and ambulance staff attending any patient passed to them by an Clinical Coordination Centres (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. Equality statement**

- 3.1 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the post. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees.
- 3.2 The Trust values differences between members of the communities we serve and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences to ensure equality of opportunity and diversity and remove any barriers that could potentially discriminate. Employees exercising their rights and entitlements under these regulations will suffer no detriment as a result. The Trust is entrusted to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.
- 3.3 The Trust is committed to ensuring equality of opportunity and the absence of unfair discrimination is provided for all employees and stakeholders in line with the

Equality Act 2010. We aim to demonstrate this equality of opportunity by removing barriers for example, an employee has difficulty in reading or writing, or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure.

3.4 We seek to demonstrate our commitment to providing equality of opportunity by:

- Ensuring that everyone is treated fairly and with respect.
- Making sure that our workspaces are safe, secure and stimulating place for everyone.
- Recognising that people have different needs and understanding that treating people equally does not always involve treating them all exactly the same.
- Recognising that some employees need extra support to help them make progress and be successful.
- Aiming to make sure that no-one experiences harassment, less favourable treatment or discrimination because of:
  - Age
  - Disability
  - Race
  - Gender
  - Gender re-assignment
  - Religion and belief
  - Sexual orientation
  - Marriage and civil partnership
  - Being pregnant or having recently had a baby.

#### **4. Roles and responsibilities**

4.1 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.

#### **4.2 Director of Patient Care and Service Transformation**

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.

#### **4.3 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.

#### **4.4 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.

#### 4.5 **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.

#### 4.6 **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.

#### 4.7 **Specialist Practitioners (previously ECPs)**

Specialist Practitioners are required to read and adhere to this policy while practicing. The Trust also employs a Pre Hospital Care Practitioner who is responsible for the strategic leadership of Specialist Practitioners throughout the Trust. Clinical guidance (see SCAS Treat and Refer Guidelines and ECP reference book) is provided for all Specialist Paramedic / Nurses via the Trust Intranet.

#### 4.8 **Clinical Support Desk Clinicians**

*Clinical Support Desks (CSDs) are based in both of the CCC's .* The Clinical Support Desk Practitioners 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 CSD 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. CSD clinicians also refer patients to alternative care pathways, where an emergency response and admission to acute hospital emergency departments is not appropriate. The CSD clinicians also provide telephone support to frontline emergency crews who require advanced clinical information to help them treat their patients most effectively. All CSD staff should read and adhere to this policy at all times.

#### 4.9 **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 its implications to other clinicians.

#### 4.10 **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.

#### 4.11 **Ambulance Nurses**

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

#### 4.12 **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.

#### 4.13 **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.

#### 4.14 **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.

#### 4.15 **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 practice to support their clinical decision-making.

### 5. **Care Pathway Procedure: Clinical Support Desk**

5.1 This section covers those instances where a CSD Practitioner decides that an emergency / ambulance response or transport by ambulance to a treatment centre is not appropriate. The Clinical Support Desk clinicians use NHS Pathways protocols for their telephone triage.

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

#### 5.3 **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 CSD clinicians. (see 6.12 of this policy "operational guidance ref patients with mental capacity issues")



- 5.4 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 2<sup>nd</sup> call) for the child to be conveyed to an assessment facility, such as those listed in 1.3, or an ED.
- 5.5 The underlying reasons for caution around a decision not to convey a younger child to hospital after an ambulance call reflect that:
- Significant illness and injury can be harder to diagnose in very young children
  - Underlying safeguarding issues can often be equally difficult to appreciate initially.

The Trust guidance, based on the 2021 NASMeD guidelines recommends that:

- **All children aged under one** with an identified (or suspected) injury or illness **MUST** be conveyed to the nearest Emergency Department (ED) which accepts children or else referred to an agreed local Trust pathway (for example referred to a GP) for further clinical assessment.

Where clinical assessment finds no evidence of injury or illness, the request for an ambulance may be to address underlying social concerns or undisclosed parental stress or illness, and therefore the child should 1) either conveyed to the ED or 2) the ambulance attendance should be notified to the patient's GP as a minimum.

- **Age one to five years** after face-to-face clinical assessment by a registered HCP this age group can be considered for handover of care and not conveyed to hospital.

If considered for non-conveyance, all clinicians must make a direct referral to another registered HCP. In most cases, during working hours, this will be the patient's own GP but out of hours may be via NHS111. A care plan or further follow up **MUST** be agreed at this point. If non-conveyance is agreed, the receiving HCP will accept the handover of care and transfer clinical responsibility at this point.

- **Age six to seventeen** after face-to-face clinical assessment by a registered HCP this age group can be considered for discharge or referral. The patient's GP should be informed of the child's need for an emergency ambulance attendance. Where the ambulance clinicians require the support of another HCP to avoid conveyance to ED, this may be via the patient's own GP or other routes such as NHS111

- 5.6 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
- 5.7 If the CSD 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.
- 5.8 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.

- 5.9 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 CSD 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 CSD practitioner should contact the relevant agency informing them of the non-conveyance decision.
- 5.10 If the CSD 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.
- 5.11 It is acceptable for the CSD 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
- 5.12 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.
- 5.13 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
- 5.14 THE CSD 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.
- 5.15 The CSD clinician should ensure that the patient is given relevant advice and contact details should their condition deteriorate.
- 5.16 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 CSD clinicians should not promise a GP visit as this is up to the downstream clinician's clinical judgment.

- 5.17 If the UCD / CSD requests a Specialist Practitioner it is not generally expected that the Specialist Practitioner will travel under emergency conditions, unless specifically requested by the CSD practitioner.
- 5.18 The UCD / CSD clinician must document that the patient has been assessed and alternative care pathways organised on the incident log on the CAD.
- 5.19 Any written or verbal advice given to the patient / carer must be recorded by the CSD clinician against the incident log on the CAD.
- 5.20 If a patient has fallen then the CSD 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.
- 5.21 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 at the earliest opportunity.
- 5.22 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.

## **6. Care Pathway Procedure: Operational Patient Facing Staff**

- 6.1 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.
- 6.2 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).
- 6.3 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.
- 6.4 **2 full sets of physiological observations, ideally spaced at least 15 minutes apart must** 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.

- 6.5 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.
- 6.6 Specialist Practitioners must always complete ePR or (if using paper documentation) the CAS 101/ 102.
- 6.7 Special consideration must be paid towards:
- 6.8 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.
- 6.9 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 2<sup>nd</sup> call for the child to be conveyed to an assessment facility, such as those listed in 1.3 or an ED.
- 6.10 The underlying reasons for caution around a decision not to convey a younger child to hospital after an ambulance call reflect that:
- Significant illness and injury can be harder to diagnose in very young children
  - Underlying safeguarding issues can often be equally difficult to appreciate initially.

The Trust guidance, based on the 2021 NASMeD guidelines recommends that:

- **All children aged under one** with an identified (or suspected) injury or illness **MUST** be conveyed to the nearest Emergency Department (ED) which accepts children or else referred to an agreed local Trust pathway (for example referred to a GP) for further clinical assessment.

Where clinical assessment finds no evidence of injury or illness, the request for an ambulance may be to address underlying social concerns or undisclosed parental stress or illness, and therefore the child should 1) either conveyed to the ED or 2) the ambulance attendance should be notified to the patient's GP as a minimum.

- **Age one to five years** after face-to-face clinical assessment by a registered HCP this age group can be considered for handover of care and not conveyed to hospital.

If considered for non-conveyance, all clinicians must make a direct referral to another registered HCP. In most cases, during working hours, this will be the patient's own GP but out of hours may be via NHS111. A care plan or further follow up **MUST** be agreed at this point. If non-conveyance is agreed, the receiving HCP will accept the handover of care and transfer clinical

responsibility at this point.

- **Age six to seventeen** after face-to-face clinical assessment by a registered HCP this age group can be considered for discharge or referral. The patient's GP should be informed of the child's need for an emergency ambulance attendance. Where the ambulance clinicians require the support of another HCP to avoid conveyance to ED, this may be via the patient's own GP or other routes such as NHS111.

- 6.11 Should this not be possible, thresholds for transporting such children to the nearest Emergency Department for further assessment should be extremely low.
- 6.12 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.
- 6.13 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.
- 6.14 General guidelines:
- 6.15 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.
- 6.16 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.
- 6.17 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.
- 6.18 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.
- 6.19 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.

- 6.20 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.
- 6.21 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.
- 6.22 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.
- 6.23 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.
- 6.24 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 / Clinical Support Desk). Details of such arrangements must be recorded against the incident on the CAD system.
- 6.25 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.
- 6.26 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.
- 6.27 The GP decision should be clearly documented. Responsibility for patient care is then transferred to the receiving clinician.

- 6.28 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.
- 6.29 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.
- 6.30 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
- 6.31 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.
- 6.32 Patient advice leaflets are available on all frontline vehicles and via the SCAS ePR system.
- 6.33 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.
- 6.34 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. This is done by completing a falls referral at the earliest opportunity.
- 6.35 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.
- 6.36 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.
- 6.37 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 be verified and added to the CARS system.

## 7. Deviation from clinical guidelines

- 7.1 All staff must adhere to the Trust's approved national and local clinical guidelines.
- 7.2 The Trust can be notified of deviations from clinical practice in a number of ways, through other healthcare professionals, complaints, claims, peer review, whistle-blowing and incident reporting using the appropriate Trust policy.
- 7.3 If staff deviate from clinical guidelines they must inform the Organisation using the Trust's Datix Reporting System.
- 7.4 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.
- 7.5 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.

## **8. Operational Guidance Reference Patient Refuses Treatment**

- 8.1 **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 clinicians professional body (e.g. HCPC, NMC or GMC).
- 8.2 *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.
- 8.3 *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.
- 8.4 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.



- 8.5 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.
- 8.6 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.
- 8.7 Where a patient declines treatment or transfer to hospital against the advice of the clinician the following procedures will be followed:
- CSD / UCD: The CSD 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.
- 8.8 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.
- 8.9 Where a patient requires medical care, but declines transport to hospital, a mental capacity assessment should be performed.

- 8.10 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.
- 8.11 Worsening instructions given by the CSD or attending clinician must be recorded on the CAD incident log and in some situations a further 999 call would be appropriate.
- 8.12 Whenever the patient declines any advice; the advice communicated to the patient is to be documented either by the CSD clinician against the incident on the CAD system or on the Patient Clinical
- 8.13 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 instances medical advice from the patient's General Practitioner (GP Triage) would be appropriate and the patient/carer should be informed.
- 8.14 The attending clinician must inform the CCC that the patient has been examined / treated / referred at scene and has refused hospital assessment.
- 8.15 **Overdoses (deliberate or accidental):**
- 8.16 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.
- 8.17 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.
- 8.18 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.
- 8.19 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.
- 8.20 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.

**8.21 Poison Information:**

8.22 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.

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

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

8.25 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.

8.26 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.

**8.27 Patient refuses Transport on Route.**

8.28 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.

8.29 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.

8.30 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.

8.31 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.

8.32 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.

8.33 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.

## 9. Monitoring

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

9.2 The monitoring will be performed by:

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

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

## 10. Other related documents

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

2. CSPP 5 SCAS Medicines Management Policy
3. CSPP 4 SCAS Patient Clinical Record Policy and Procedure
4. South Central Ambulance Service NHS Foundation Trust Patient advice leaflets.
5. CSPP 7 SCAS Care Pathway Policy
6. GP Triage protocol (SOP)
7. GP Triage protocol (SOP) residential and nursing homes
8. Capability Policy
9. Whistle blowing Policy
10. Duty of Candour policy
11. AACE / Joint Royal College of Ambulance liaison committee (2016)
12. Job Descriptions for Consultant Pre-Hospital Care Practitioner and Specialist Practitioner
13. South Central Ambulance Service – Mental Capacity Policy
14. Mental Capacity Act Flow Chart

## 11. **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.

## 12. 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. Staff should lower their threshold for conveyance to hospital for patients with head injury who are taking anti-platelet medication, such as Clopidogrel. All patients on warfarin or other anticoagulant therapy (including the NOVEL anticoagulants but excluding aspirin) must 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.



### 13. 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

14. Appendix C:



# CLINICAL INVESTIGATION TOOL

	Pulse	Resp rate	Blood Pressure	Blood Sugar	GCS Assessment	Urin alysis	Temp	O2 Sats	Peak Flow	Peak Flow (post neb)	12 lead ECG	3 lead ECG	Pain Score	FAST assesment	Blood pressure both arms	"Get up and go" Test	4 part mental test	Consider ECP	Vulnerable adult form	Limb Observations	Falls Form	C-spine clearance form						
Abdominal pain	RECORD FOR ALL PPTS	RECORD FOR ALL PPTS	RECORD FOR ALL PPTS																									
Allergic reaction																												
Asthma																												
Back pain																												
Collapse																												
Chest pain (do not delay transport for investigations)																												
Cardiac arrest (post ROSCO)																												
Diabetic problems																												
Fall (explained mechanical)																												
Fits																												
Fractured neck of femur																												
Haemetemesis																												
Headache																												
Head injury (patients on warfarin must be conveyed)																												
Minor lacerations																												
Minor rtc																												
Overdose																												
"Panic" attack / hyperventillation																												
Shortness of breath																												
Social problems (vulnerable / elderly)																												
Stroke (do not delay transport for investigations)																												
"Unwell" child																												