South Central Ambulance Service
NHS Foundation Trust

MULTIPLE OPERATIONAL RESOURCE ON SCENE PROCEDURE

South Central Ambulance Service NHS Foundation Trust
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DOCUMENT INFORMATION

Author:	Deb Ingram, Clinical Operations Manager, South
Consultation & Approval:	Staff Consultation Process (21 Days) from 07.03.2012 Governance Committee Board Ratification if appropriate
This document replaces:	New procedure and guidance
Notification of Procedure Release:	Staff Notice Boards SCAS internet & Intranet Staff E-mail
Equality Impact Assessment:	Stage 1 Assessment undertaken – no issues identified
Date of Issue:	November 2018
Next Review:	November 2020
Version: 2	Version 4

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1.0 PURPOSE

1.1 The purpose of this procedure is to provide Operational and Emergency Operations Centre (EOC) staff with guidance to achieve a reduction, where clinically safe to do so, in the amount of time multiple operational responses are at scene together. This will release operational resources to improve patient care as well as improving operational performance.

2.0 SCOPE

2.1 This procedure applies to all South Central Ambulance Service NHS Trust (SCAS) Clinical and EOC staff including Operational Managers, Specialist Paramedics (SP), Paramedics, Trainee Associate Ambulance Practitioners (TAP), Associate Ambulance Practitioner (AAP), Emergency Care Assistants, Technicians, Ambulance Nurses, HART Operatives, BASICs Practitioners and Clinical Support Desk Clinicians.

3.0 DUTIES

3.1 It is the responsibility of all clinical staff to follow the guidance outlined within this procedure. If a prolonged period of time (20 minutes plus) is going to be spent at scene by a multiple resource that will not be conveying a patient, then the EOC should be informed with the reason for this and an estimated time when that resource will become available. At very busy times EOC may ask the resource to leave the scene to attend an emergency if it is safe clinically to do so.

3.2 **Chief Operating Officer** has Board level responsibility for the review and implementation of operational procedure and guidance within South Central Ambulance Service NHS Trust.

3.3 **Operations Directors and Assistant Director of EOC** have delegated responsibility for managing the strategic development and implementation of clinical and non-clinical operational policies and should apply this procedure throughout the Trust ensuring it is available to staff and adhered to.

3.4 **Head of Operations and EOCs** will be responsible to the Operations Directors and Assistant Director for EOC for the development of effective Trust wide policies and procedures. Specific responsibilities will include monitoring compliance of this procedure and the performance management of staff.

3.5 **Clinical Operational Managers and Control Managers** are responsible for implementing this procedure within the operational environment. They report to the Head of Operations /EOC and should make this procedure available to all staff within their departments. Clinical Operation Managers and Control Managers should read and fully understand this procedure with specific responsibility for monitoring all areas of this procedure and the performance management of staff against the procedure.

3.6 **All Operational and EOC Staff** are required to read and adhere to this procedure when attending a scene with multiple resources in attendance. If a prolonged period of time is going to be spent at scene by multiple resources that will not be conveying a patient, then the EOC should be informed with the reason for this and an estimated time when that resource will become available.

3.7 This applies to all SCAS clinical staff including Operational Managers, EOC staff, Trainee Associate Ambulance Practitioners (TAP), Associate Ambulance Practitioner (AAP) Emergency Care Assistants (ECA), Technicians, Paramedics, Specialist Paramedics(SP), Ambulance Nurses, HART Operatives, BASICs Practitioners and Clinical Support Desk Clinicians.

4.0 PROCEDURE BACKGROUND INFORMATION

4.1 The Trust has been looking at various ways of improving patient care and operational performance within its existing operational resources. An audit of statistical information highlighted differences between Areas across the Trust in relation to the amount of time multiple operational resources were on scene without conveying a patient.

4.2 A review of Trust policies highlighted a need for guidance to both clinical and EOC staff regarding good practice when multiple operational resources were at the scene of an emergency incident.

4.3 The benefits of reducing the time that multiple resources are at scene are:

4.3.1 Quality of patient care improved by releasing ambulance/solo response vehicle (RRV) resource earlier to attend further deployments, therefore reducing the amount of time patients have to wait for an ambulance resource.

4.3.2 Reduction in the amount of overruns and meal breaks missed at busy times.

4.3.3 Increase in operational performance by increasing the amount of resources available.

4.4 The Trust recognises that there are always occasions that require an operational resource that will not convey a patient, providing assistance at a scene. This procedure is intended to give guidance to operational crews and EOC staff to manage this in the most effective way to optimise patient care.

5.0 PROCEDURE

5.1 The purpose of this procedure is to provide Operational and Emergency Operations Centre (EOC) staff with clinically safe guidance to achieve a reduction on the number of occasions and in the amount of time multiple operational resources spend ‘on scene’. This will release operational resources to improve both patient care and operational performance, whilst improving the efficiency of our resource management.

This procedure links to the EOC Standing Operational Procedures for the dispatch of 'back up' to Rapid Response vehicles. Automatic 'back up' must be sent for RRVs for the following event types:

- Adult and Paediatric Cardiac arrests
- Chest pain of possible cardiac origin
- Acute Stroke Symptoms
- Acute neurological Symptoms
- Meningitis Symptoms
- Obstetric Emergencies
- Acute respiratory distress
- Fitting continuously (status Epilepticus) or
- First fit & still fitting at the time of the call
- Unconscious
- Significant Trauma
  - Gunshot/stab wounds to head /neck/torso
  - Drowning
  - Electrocution
  - Hanging
  - High speed motorcyclist/cyclist collisions
- RTC
  - Patient Trapped
  - Patient Ejected from vehicle
  - High Mechanism Crashes
  - Pedestrian hit at 20mph or more

Consideration should also be given to the skill mix attending the patient in case Paramedic skills are required at the scene.

For all other incidents the EOC will wait for an update from the responding RRV to request a transporting vehicle.

5.2 SP/RRV - Once they have completed their clinical assessment and are happy that they do not require an additional operational resource, they should contact EOC at the earliest opportunity and inform them that they do not require additional backup.

If back up is required, then a status request should be sent from the Tetra hand portable to request back up. This should be confirmed through verbal communication with EOC to confirm the type of response and clinical level required (i.e. Clinical or DECA crew).

If an immediate response is required due to the patients presenting condition being time critical EOC must be informed immediately. EOC will then allocate the next closest resource to the incident.

5.3 Operational Staff who will not be conveying a patient or treating the patient at the scene should book 'clear' and become available as soon as it is clinically safe to do so.

5.4 If multiple resources are attending a patient then the first operational resource on scene should complete the relevant sections of the Patient Care Record (PCR)/ Electronic Patient Report form (EPR), if appropriate, identifying any observations or treatments they have undertaken prior to booking clear.

When the second or conveying resource is allocated the call, the Patient Record will be transferred or be available to be accessed, by this resource to update and complete en-route to the relevant Treatment Centre. The clinical handover must be completed as efficiently as possible to allow the release of the first resource on scene.

5.5 If a prolonged period of time (20 minutes after the second ambulance response has arrived) is going to be spent at scene by a multiple operational resource which will not be conveying a patient, then the EOC **must** be informed with the reason for this and an estimated time when that resource will become available. This information should be recorded within the CAD Incident Record.

5.6 **Parking at Scene:** It has become apparent that on a number of occasions the RRV/ECP/DCA on scene has been blocked in by the second resource thereby preventing the first resource from leaving the scene.

Care should be taken to avoid blocking in any operational resource if feasible to do so, thus allowing the DCA/RRV to book clear and leave the scene for further deployments without delay.

5.7 **Ambulance Equipment:** If the patient's condition allows, the first on scene vehicle should contact EOC with the specific ambulance equipment (including specialist resource, i.e. bariatric, HART, required to manage the patient/s. This will be passed to the supporting resource. Alternatively, EOC can provide the supporting vehicle with the call sign and ISSI number of the attending vehicle to facilitate communication via Tetra.

5.8 The second attending resource, whether DCA/RRV, should attend the patient with their r e q u e s t e d e quipment so allowing the first response to exchange equipment and restock and book available once a patient handover has taken place.

5.9 **Specialist Paramedic (SP) Called:** Under normal circumstances all calls that the crew believe are suitable for an SP should be passed to the Clinical Support Desk (CSD) for consideration if available. If the CSD clinician deems that the call is appropriate, then the crew should clear ASAP. A full clinical handover should be passed to the CSD Clinician, if appropriate then the crew leaving the scene can contact the responding SP and give them a clinical handover.

This should be completed through a recorded line or via phone patch from the CSD/EOC. It is vital that a correctly filled EPR is available for the attending Specialist Paramedic.

5.10 If the patient's clinical condition requires the operational crew to stay at scene until the SP arrives, the EOC must be informed and the reasons for the crew to stay at scene entered into the CAD Patient Record. As soon as the SP arrives, a patient handover will take place and agreement reached regarding transportation. If not required, the operational crew should book available immediately.

5.11 **Additional Paramedic/SP/Band 4 Clinician travels to hospital:** There are occasions on clinical grounds for additional operational staff are required to travel with the patient to Hospital Emergency Departments, either as support or as the lead clinician. In this situation the clinician must travel with the ambulance and not follow behind in their vehicle if additional clinical support is required.

5.11.1 It is suggested that the least clinical member to drive the RRV/DCA to hospital under normal road conditions, not using Emergency audible/visual warning devices.

5.11.2 If a vehicle is left on scene because additional assistance is required in the rear of the ambulance, the following will apply:

EOC must be informed and confirm that the ambulance can take the single person back to their vehicle.

EOC should consider arranging for a Team Leader, Officer/Manager to return the staff member back to their vehicle. If the journey time exceeds 15 minutes, especially during periods of high demand. This will allow the DCA to be deployed when it comes available.

5.12 **HIOWAA & TVCAAT Helicopters:** The senior clinician on the aircraft, where the patient's condition allows, can stand-down operational resources/BASICs etc. (To be reviewed in line with progression of this resource).

5.13 **EOC: Multiple Patients Incidents:** Will monitor the amount of time that multiple resources are on scene. If the EOC does not receive an **ETHANE** update from the scene of a multiple resourced incident within 10 minutes of the time the second resource arrived on scene, they should contact the crews concerned and ask for an update. EOC should record all reasons for prolonged double resourcing at scene in the CAD Patient/Incident record.

5.14 The EOC should send a Team Leader or Manager to all emergency incidents where more than four DCA/RRV resources have been asked to attend. A management resource should also be sent to any receiving hospital with more than three ambulances from the same incident. This is to support ambulance crews at scene and to assist in a smooth turn around at hospital.

6.0 MONITORING

6.1 The monitoring of this procedure will be through the Area Performance Management Framework at levels 1, 2 and 3.

6.2 The Operations Directors will be jointly responsible to delegate a Head of Operations to carry out a yearly review of this procedure and will provide a report to the Performance Management Group (level 3) and the Operational Procedure Review Group which will include:-

6.2.1 Review of the procedure to see that it is still current and does not need updating.

6.2.2 Statistical data of compliance at Station and Divisional level.
6.2.3 Number of Datix relating to the procedure
6.2.4 Number of disciplinary issues relating to non-compliance of the procedure.

6.3 Any action plans developed to improve this procedure will be monitored by the Performance Management Framework at levels 1, 2 and 3 for effectiveness.

7.0 REVIEW

7.1 This procedure will be reviewed on an annual basis or sooner in the light of any changes in guidance and guidelines to which the Trust must adhere.

8.0 EQUALITY & HUMAN RIGHTS IMPACT STATEMENT

8.1 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marital status, disability, race, nationality, gender, religion, sexual orientation, gender reassignment, ethnic or national origin, beliefs, domestic circumstances, social and employment status, political affiliation or trade union membership, HIV status or any other basis not justified by law or relevant to the requirements of the post.

8.2 By committing to a procedure encouraging equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

8.3 The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of race, ethnic or national origin, colour or nationality; gender (including marital status); age; disability; sexual orientation; religion or belief; length of service, whether full or part-time or employed under a permanent or a fixed-term contract or any other irrelevant factor.

8.4 Where there are barriers to understanding e.g. 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. Further information on the support available can be sought from the Human Resource Department.

9.0 REFERENCE & READING

- Risk Management Strategy
- Adverse Incident and Reporting & Investigation Procedure
- Patient Clinical Records Procedure
- Emergency Care Practitioners Procedure
- Care Pathway Procedure
- Control Standing Operational Procedures

- JRCALC Guidelines
- Trust Job Description
- Trust's Transport of Patients by Solo Response Vehicles
- EOC immediate RRV back up procedure.

Equality Impact Assessment Form: Section One – Screening

A full Equality Impact Assessment has been carried out on this policy and is available on request to the public and internally via our Staff Intranet.

Equality Impact Assessment Form Section Two: Full Assessment

A full Equality Impact Assessment has been carried out on this policy and is available on request to the public and internally via our Staff Intranet.