London Ambulance Service NHS Trust

Managing the Conveyance of Patients Policy and Procedure

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To define the process for managing the conveyance/ non-conveyance of patients

Sponsor Department: Medical Directorate

Author/Reviewer: Senior Clinical Adviser to the Medical Director. To be reviewed by June 2013.

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25/08/10	0.3	Senior Clinical Adviser to the Medical Director	Addition of Patient Groups - Conveyance Requirements table.
15/04/10	0.2	Senior Clinical Adviser to the Medical Director	Added scope, responsibilities. Refined objectives, expanded monitoring and non-conveyance of patients
03/02/10	0.1	Senior Clinical Adviser to the Medical Director	First draft

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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Links to Related documents or references providing additional information		
Ref. No.	Title	Version
	IHCD Training Manual.	
	Road Traffic Act.	
	LAS Infection Control Manual.	
TP/014	Procedure for Ambulance Observers.	
OP/001	Dress Code for Uniformed Staff	
HS005	H&S Manual Handling Policy	
	Data Protection Act 1998	
OP/031	Policy for Consent to Examination or Treatment	
OP/011	Minor Injury Units & referral to health & social care	
LA004	Patient report form (PFR)	
TP/003	Policy Statement of Duties to Patients	
TP/014	Procedure for Ambulance Observers	
OP/001	Dress Code	
OP/010	High Risk Register	
OP/028	Advanced Directive/ PSP	
TP/018	Suspected cases of Child Abuse	
TP/019	Suspected abuse of Vulnerable Adults	
LA052	Incident Reporting Procedure	
HS012	Violence Prevention Procedure	
HS011	Incident Reporting Procedure	
TP023	Driving and Care of Service Vehicles, Collision Reporting, Investigating and Adjudication.	
	BMA Mental Capacity Act Guidance	
	Assessment of Capacity	
	DH Guidance - Working together to safeguard children	
	Clinical Practice Guidelines for Use in UK Ambulance Services (JRCALC Guidelines)	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

The London Ambulance Service attends a diverse range of patients, often in unique and demanding circumstances. This procedure aims to capture the entire patient journey from the point a resource arrives on scene to the point of discharge from ambulance service care. The actions we take to provide care are crucial in providing patients with a timely and appropriate experience. In order to provide fluid care we need to maintain close working relationships with partner agencies and care givers.

2. Scope

This policy provides general guidance to staff in relation to the most appropriate treatment, conveyance and referral of patients. It does not seek to provide detailed guidance, but does signpost staff to the relevant detailed guidance/ policy where required.

This policy applies to all patient groups. Where required advice/ guidance regarding specific patient groups, such as children or vulnerable adults, will be distinctly identified.

3. Objectives

3.1 To ensure that staff are appropriately advised of the action to be taken on scene.

3.2 To improve communication between LAS staff and professional colleagues

3.3 To help ensure that all patients who are conveyed by the LAS receive optimum care during their journey based upon their clinical condition, safeguarding the interests of both patient and staff

3.4 To help ensure that all patients attended by the LAS are offered conveyance to a destination most suited to their clinical needs.

3.5 To ensure that the best use of Alternative Care Pathways, eg. Falls Services etc. and referral to GPs is considered.

3.6 To minimise risks that can occur whilst on scene.

3.7 To ensure that adequate support is available for staff to call upon when working in vulnerable situations.

3.8 To ensure that staff are appropriately informed of the action to be taken on

scene

3.9 To provide clarity for both LAS and hospital staff of their role in the handover of a patient, ensuring the provision of seamless patient care.

3.10 To ensure the patient is handed over in a safe and timely manner within the 15 minute LAS hospital handover time standard.

3.11 To help ensure that patients who are not conveyed for any reason are offered appropriate care and advice based upon their clinical needs, safeguarding the interests of both patient and staff.

3.12 To identify when responsibility for the patient transfers from the LAS to another responsible person or agency.

3.13 To ensure that staff are appropriately informed in the recognition of life extinct procedure and the management of deceased patients.

4. Responsibilities

4.1 The Quality Committee provides assurance to the Trust Board on clinical, corporate, information governance and compliance matters ensuring high quality care to patients. It will review the Board Assurance Framework and Corporate (Trust) Risk Register and ensure that risk management is on the governance agenda throughout the organisation. Key agenda items would include seeking assurance on the CQC regulatory outcomes and the preparation for the NHSLA risk management inspection; seeking assurance from within the organisation that patient safety was being managed effectively; and that effective processes are in place to manage and monitor hygiene/infection control and safeguarding.

4.2 The Clinical Quality Safety & Effectiveness Committee oversees the arrangements within the Trust for managing clinical safety and quality. This will include clinical governance and clinical risk, as well as reviewing evidence and outcomes and developing or improving clinical practice. It has particular responsibility for ensuring the provision of high quality clinical care within the LAS, and managing the risks associated with that. It works closely with the Risk Compliance and Assurance Group to ensure that the management of all significant risks is monitored through one or other of the committees. The committee will have delegated responsibility for a number of the CQC regulation outcomes.

4.3 The **Chief Executive**, as the Accountable Officer, has overall accountability for having a robust risk management system in place and an effective system of internal control, which is embedded within the Trust. The Chief Executive has delegated day to day responsibility for all aspects of risk management to nominated Executive Directors for their respective areas in line with the Risk Management Policy and Strategy (TP005).

4.4 The **Medical Director** has delegated responsibility for managing the strategic development and implementation of the treatment and conveyance, (or discharge) of patients to a requisite care facility.

4.5 The **Director of Operations** has delegated responsibility for managing risks associated with the transfer of patients.

4.6 Assistant Director of Operations and Area Operations Manager(s)

The **Assistant Director of Operations & Ambulance Operations Managers** have responsibility for the day to day delivery of staff and vehicles to allow the treatment and conveyance, (or discharge) of patients to an appropriate care facility.

The **Assistant Director of Operations** has delegated responsibility for managing Control Services, and for delivering the transfer process in line with the Risk Management Policy and Strategy within the Operations directorate.

4.7 Clinical / Operational Staff

Operational Staff are responsible for the day to day delivery of the treatment and conveyance, (or discharge) of patients to an appropriate care facility. This includes (but is not limited to) Duty Station Officers (DSOs), Team Leaders (A&E and PTS), Emergency Care Practitioners (ECPs), Paramedics, Student Paramedics, Emergency Medical Technicians, Urgent Care Staff, Patient Transport Service (PTS) and Control Services staff.

Clinical / Operational Staff responsibilities are fully set out within TP03 "Statement of Duties" (see Appendix 1). The principle responsibilities of Clinical **/ Operational Staff** are set out below

- Always work within LAS Trust policies and procedures.
- Recognise and work within the limits of their professional competence by undertaking duties and responsibilities which they are able to perform in a safe and skilled manner.
- Provide clinical leadership by assuming overall responsibility for a patient (or task) once it has been established that they have a higher level of competency than other staff on scene.
- Handover the management of a patient (or task) where there is a more senior clinician in attendance.
- Keep clear, accurate and up to date patient records which report the relevant clinical findings, decisions made, and all treatment administered to the patient.

- Maintain and improve their professional knowledge, skills and competence through ongoing personal development.

- Observe the professional principles of integrity, honesty and patient confidentiality.

- Refrain from knowingly participating in any act or deed that could be deemed unethical.

- Do nothing to undermine public confidence in the Service.

- Maintain and promote the professional standing of the LAS in the wider health care setting and with other emergency services and agencies.

Clinical / Operational staff should undertake their assessment and management of patient's in line with the Joint Royal Colleagues Ambulance Liaison Committee National Clinical Guidelines and their level of training and Professional Regulations (if appropriate)

4.8 All Staff

It is the responsibility of **all staff** to identify risks and to highlight these to the appropriate manager, via the Untoward Incident Reporting Procedures. Employees also have a responsibility to cooperate with managers and to contribute to the process of identifying and reducing risks.

5. Definitions

5.1 Conveyance

The definition of 'conveyance' for the purposes of this policy is based upon the following:

> "The transfer of patients, medical and clinical personnel, equipment and associated records, as appropriate including from one healthcare facility to another as well as the initial journey from the scene."

NHS Litigation Authority Risk Management Standards for Ambulance Trusts 2010-11.

5.2 Patient Groups

For the purpose of this document patients are defined in the following groups (see table on next page).

Patient Group	Definition*	Conveyance Requirements (transfer, medical/clinical personnel, equipment, associated records)
Adults	Age 16 and over	section 9 to 16
Paediatric Patients	Age under 16 This patient group are patients under 16 years old.	There are a number of facilities in London that do not accept patients under the age of 16. The Clinical Support Desk has up to date details of which departments will not accept paediatric patients. So also section 10.1
Patients conveyed direct to a Primary Angioplasty facility	This patient group is defined in the cardiac information circular (being written).	This patient group is conveyed direct to facility that if required can perform primary angioplasty. This is set out in the cardiac circulars "available on the pulse" http://thepulse/uploaded_files/Patients/11-cc_circular_cardiac_admission_to_cathlab_011.pdf
Major Trauma	These patients are defined by triggering the Major Trauma Decision Tree and the Clinical Co-ordination Desk should be informed.	This patient group are patients conveyed direct to a Major Trauma Centre. This is set out in Operations Bulletin http://thepulse/uploaded_files/bulletins_other/a_e_ccd_launch_010410.pdf & Medical Directors Clinical Update http://thepulse/uploaded_files/Clinical%20Update/ClinicalUpdate21-Mar10.pdf
Hyper Acute Stoke	Are defined by the Medical Director's Bulletins relating to Stroke.	This patient group are patients conveyed direct to a Hyper Acute Stoke Unit. This is set out in Medical Directors Bulletin http://thepulse/uploaded_files/bulletins_other/medical_bulletin_12jul10_stroke_phase_two.pdf
Obstetrics	This group of patients is defined by JRCALC obstetrics sections.	This patient group are patients conveyed direct to obstetrics facility. This is set out in JRCALC http://thepulse/uploaded_files/national%20clinical%20guidelines/birth_imminent_normal_delivery_and_delivery_complications.pdf and OP35 Obstetrics Care Policy http://thepulse/uploaded_files/Forms/2010-02-22__op036_paediatric_care_v1.2.pdf
Minor Injury Unit & Walk in Centres	This patient group are patients who are conveyed to Minor Injury Unit & Walk in Centres.	section 21 The pathways for these units are the patients they accept are listed on The Pulse on the complex home page.
Referred to another Health care professional	This patient group are patients who are not conveyed to a facility but referred to another Healthcare professional for onward assessment, treatment and care	section 21

**It should be noted that these definitions are for guidance in relation to this policy and definitions may vary for other polices and procedure*

6. Documentation

The documentation to be completed for each episode of patient care is covered in detail in the Assignment Record and Clinical Record Form User Guide.

This guide details the process for documenting all treatment provided (p.12 Treatment and Management section), including what documentation must be left with the patient, or to accompany them when being conveyed to a treatment centre etc, in various circumstances (p.4 Guidelines for Completion).

7. Guidelines

7.1 Local Guidelines

Consent for examination and treatment must be gained for any patient treated by a member of LAS staff. Detailed guidance on consent to examination and treatment, and also on refusal to examination, treatment to transport is dealt with in OP031 Policy for Consent to Examination or Treatment (Part B, section 2).

7.2. Management of Deviation from National Guidelines

If any deviation from the accepted national clinical guidelines for the treatment of a patient is being considered then the detailed advice in OP/ 040 Policy Advising Staff where Deviation from Guidelines is Considered (section 6).

8. Assessment, Diagnosis and Treatment Regimes

The process of assessment, diagnosis and treatment regimes should be carried out according to the JRCALC guidance, clinical training and professional regulations (if appropriate). Sections 9 to 16 set out the guidelines and specific actions to be taken when conveying a patient.

The type of information that needs to be given to the patient by the ambulance clinician will vary depending on circumstances and urgency, and should be based on the description and method of treatment, transport and on-going care. The Clinician should inform the patient of possible complications and side-effects and treatment options. This is set out in the Policy for Consent to Examination or Treatment OP/31.

9. Initial Actions on Scene

On arrival at the call location, the mobile data terminal (MDT) should be updated and the time recorded on the Patient Report Form (PRF). The time of arrival at the patient must also be recorded when completing the PRF.

Ambulance staff arriving at the location given via the MDT, yet unable to locate the patient must contact Emergency Operations Centre (EOC) with this information and commence an 'area search'. During the area search, EOC will, attempt to make contact with the caller to confirm the location. The LAS has a responsibility to take all reasonable steps to locate the patient.

When attending an emergency call, the minimum equipment to be taken to scene includes the oxygen bag and primary response bag (including AED). Additional items such as collars, suction, paramedic bag etc. should be taken based on a dynamic assessment of the call details.

Those persons working on MRUs and CRUs will need to adapt Section 1.3 above to suit the manner in which equipment is packaged and carried on the MRU/ CRU. As in Section 1.3 above, a dynamic assessment of the call details will determine what other equipment is taken into the call.

If despite all efforts the patient is not found, EOC must record on the Emergency Call Receipt form (AS1) 'area search, no trace' along with a record of attempts to "ring back" with the resulting outcome. Ambulance staff must record 'area search no trace' (code 9013) on the PRF.

If a patient is being transferred from a place of care and the patient is not ready the following should be noted:

If the delay is expected to exceed 15 minutes then the EOC must be informed immediately and the crew should remain in contact with EOC. The final decision on whether ambulance staff should be re-deployed rests with the Operations Centre Manager (OCM). Effective liaison between ambulance staff and EOC is essential.

9.1 Forced Entry by Ambulance Staff

In the instance of ambulance staff being unable to gain access to a property they should contact EOC to confirm the address and that all relevant information has been received. If it is obvious that there is somebody in the premises that requires urgent assistance then the crew need not wait for further permission from EOC. Examples would be where the crew can see the patient lying unresponsive on the floor with signs of blood loss evident, or a patient lying on their back unresponsive.

Action to be taken by EOC

Before authorising a crew to make a forced entry into a private property, EOC should carry out the following checks:

- Listen to the tape recording and confirm that the crew have identified the correct address

- Ring the telephone number provided for that address or the caller/ informant

- Contact the police and advise them of the potential for a 'collapse behind locked doors'

- Ask the crew to establish from neighbours, relevant information on the occupant and the location of spare keys to the property if known

- Once EOC are satisfied that there is likely to be a person in the premises that requires *urgent* medical help, permission may be granted to the crew to make a forced entry, if police are not in attendance.

- The patient should be seen or heard to be in distress before an entry is forced and their consent should be sought where possible

Staff should carry out a dynamic risk assessment, balancing the need for a fast entry, with their safety. Following this assessment, an entry with the minimum amount of damage and minimum personal risk may be attempted.

In the instance of a forced entry it is critical that EOC is made aware as soon as possible. EOC staff will advise the police and unless the patient's condition is deteriorating quickly, the crew should remain on scene until arrival of the police.

Where the patient's condition is time critical and requires immediate removal, an attempt should be made to secure the premises in the best way possible and to leave it looking visibly secure. Depending on the circumstances it may be appropriate to ask a neighbour to look after the premises until the police arrive.

Any forced entry in to a property should be documented on the PRF including the reasons for doing so, the condition of the patient and the efforts made to secure the property before departure.

9.2 Safety on Scene & Staff Welfare

When on scene it is paramount that ambulance staff first protect themselves, their colleagues, the patient and any other persons on scene. Once ambulance staff arrive at an incident, there may be instances where further Personal Protective Equipment (PPE) may be required. If the scene is for any reason considered unsafe, staff should initially withdraw and immediately contact EOC.

Close liaison must be maintained at all times with other emergency services and, where appropriate, the senior safety officer or other responsible person on scene.

If, on arrival at scene, staff discover the call falls within the remit of the Road Traffic Act (this includes incidents such as falling from a bus) they should inform EOC as soon as possible and where injury has occurred, request the attendance of police. If the police have not arrived before conveying the patient, the crew should again, inform EOC of this fact and the hospital to which they are conveying the patient.

Although the personal safety of the ambulance crew is a priority the safety of patients and others at scene remains paramount. This may, for example, include the protection of the patient during a difficult extrication where cutting equipment is in use. Ambulance staff must inform the patient of the intended actions to be taken which may affect the patient, the situation or the outcome in any way.

All ambulance staff must proceed with caution when confronted with potentially violent situations and must place their own safety first. If faced with threatening behaviour, ambulance staff should make all efforts to diffuse the situation remaining calm, respectful and polite at all times. Further guidance is available in the Violence Prevention Procedure H&S/012.

If unsuccessful and the situation persists or escalates, staff should withdraw and seek assistance via EOC. Form (LA277) must be completed. Please refer to the Incident Reporting Procedure H&S/011 for additional guidance.

If ambulance staff subsequently feel they need further support or assistance once the incident is complete, they should contact EOC who will contact the appropriate manager. Any untoward incidents should be reported using the incident reporting form (LA52). Further guidance is available in the Incident Reporting Procedure H&S/011 – available on the pulse.

9.3 Patient Communication and Interaction

Due to the diverse population that the LAS serves it is probable, ambulance staff will come into contact with patients where there are communication difficulties. These difficulties may cause the patient further distress and anxiety, thus limiting patient assessment. Support and guidance is provided for ambulance staff through the LAS Multi Lingual Emergency Phrase Book and Ethnic Health and Cultural Awareness Information Handbook. In extreme situations, where medical circumstances dictate, staff should contact EOC who can access an interpreter. Operational ambulance staff have access to Language Line via their personal Emergency Crew Assistance (ECA) mobile phone. Communication difficulties may come in one of many guises and LAS staff must make every effort to ensure that the patient is involved in all decisions surrounding aspects of their care.

LAS staff are constantly in contact with patients from different cultures. Staff must treat all patients equally affording them courtesy, respect and politeness at all times. Under no circumstances should a patient be treated less favourably than another on any grounds. (See also the LAS Equality and Diversity Statement - http://thepulse/managing/1048696554.html)

As representatives of the LAS, ambulance staff should ensure that they conduct themselves in a manner that reflects both their own and the Service's professional standing. A professional approach includes:

- Wearing LAS uniform in accordance with the Dress Code for Uniformed Staff,
- body language that imparts sympathy and understanding,
- interpersonal and clinical skills that allow ambulance staff to assess each patient in a calm, confident and methodical manner.

Staff should be aware that their actions on scene may be witnessed by third parties who may feel that an action, inaction or statement is inappropriate for the circumstances. Staff should make every effort to explain their actions to those who have reasonable cause or grounds to request such information.

A patient's behaviour may at times appear unreasonable, but despite this staff should not be drawn into arguments. Any problems should subsequently be referred to a line manager and documented on the PRF.

Disagreements between LAS staff or with other Health Care Professionals must never take place in public places or in view or hearing of the patient or general public.

9.4 Patient Welfare

Ambulance staff have a responsibility to record on the PRF and report to the hospital staff during handover, any concerns they may have about the patients' home environment, e.g., cold, damp, unsanitary conditions, no food provisions or a dangerous appliance or structure.

When the patient is being conveyed to a home address which is found to be unhealthy or unsafe it should be reported to EOC as soon as possible before leaving the premises. A consensus should be reached between clinical staff on scene and EOC (including the Clinical Support Desk) on what appropriate action to take, e.g., locally agreed access pathways to social services and where cases of abuse or vulnerability are suspected, implementation of TP/018 or TP/019.

Wherever possible the patient's property should be left with the patient, or a person accompanying the patient (where it may reasonably be assumed that such a person will be acting in the best interests of the patient). There may, however, be some circumstances, where the patient, or any other person, is

unable to take responsibility for the patient's property and, in these instances; the items should be taken to hospital with the patient, using the designated patient property bag. The bag should be sealed in the presence of the patient, the details completed and a record of the bag number made on the PRF. The bag should be passed to hospital staff at the handover of care; the tear-off strip should be attached to the copy of the PRF handed to the hospital, or given to the patient, if necessary secured around the patient's wrist.

If, however, the property is bulky and not easily transportable, for example a bicycle, attempts should be made for it to be secured at scene and only as a last resort stored as securely as possible in the vehicle and conveyed with the patient. Arrangements should be made at the hospital site to secure the item, and for the patient to be notified accordingly either by LAS staff or by hospital staff. Any action should be documented on the PRF.

Ambulance staff should always check the cab/saloon of the ambulance for patient property before leaving the receiving unit. If any items are found, the procedure described in paragraph 5.3 should be adhered to.

The Patient Experiences Department will host enquiries relating to patient property. Where information is not documented on the PRF, the matter will be referred to the relevant complex management team to resolve matters locally. Local managers should be aware of the requirement to advise an enquirer of their right to make a formal complaint and/or a compensatory claim. In this event the matter should be referred to the appropriate department.

If it is brought to the attention of ambulance staff that a patient in need of conveying has sole responsibility for an animal, reasonable measures should be taken to ensure that the animal is subsequently cared for.

If the patient is in a public place when receiving emergency care and has an animal with them, ambulance staff should ascertain whether there is an appropriate person on scene to take short term responsibility of the animal. If not EOC should be informed and asked to contact the police. As an absolute last resort and at the discretion of staff the animal may be conveyed with the patient. Guide dogs must be conveyed as a matter of course.

If the patient is in their own environment and a neighbour is available it may be appropriate to ask them to ensure the animal is looked after. If this is not the case, then ambulance staff should contact EOC who will inform the police or appropriate services.

Used equipment, soiled dressings and/ or sharps should NOT be left on scene. If waste is generated at any time whilst attending a patient, it must be disposed of according to service policy and in accordance with the LAS Infection Control Manual.

Patient medication should always accompany the patient using the green pharmacy bag provided by the LAS to their destination. The patient details must

be written on the front of the bag in the box provided or a hospital label with these details attached. This should be documented on the PRF and handed to the receiving hospital staff.

9.5 Patient Protection

Everyone has a responsibility to report a suspicion of criminal offence. Ambulance staff, in common with other NHS staff, also have a duty of confidentiality towards their patients. These priorities need to be balanced to ensure that appropriate medical care is provided for all patients whilst alerting police to a crime or crime scene.

If ambulance staff believe or suspect that their patient is involved in a crime they must continue to treat that patient and, if necessary, convey to hospital. Staff must immediately inform EOC, or advise hospital staff, to inform the police of their suspicions or evidence. In any event, EOC must always be informed so that the call log can be updated to reflect this information.

Where there are unusual or suspicious circumstances, staff should take reasonable precautions to preserve the potential crime scene, and await, if appropriate, the arrival of the police.

Staff are responsible for reporting all instances of abuse which they are made aware of. In the case of a child any **suspicion** of abuse must be reported. Vulnerable adults, notably the elderly and disabled may also be subject to abuse. The appropriate forms must be completed and the incident reported.

If staff suspect a child is being abused, TP/ 018 Suspected Cases of Child Abuse Procedure must be implemented. Additional guidance is available in the JRCALC National Clinical Guidelines.

If staff suspect an adult is being abused, TP/ 019 Suspected Abuse of Vulnerable Adults Procedure must be implemented. Additional guidance is available in the JRCALC National Clinical Guidelines.

The situation must be documented on the PRF and the appropriate Child Protection Report Form (LA279) or Protection for Vulnerable Adult Form (LA280) must be completed. The receiving A&E Nurse /Doctor must be notified at hand over of the completion of a referral form and the circumstances surrounding the patient. The receiving clinician's name and designation must be recorded on the PRF.

If the victim of suspected abuse is the patient but not conveyed, or the victim is not the patient at the location, ambulance staff must complete the relevant form (LA279/ LA280). Ambulance staff should then be made unavailable so they can complete the reporting procedure as per section 4.1.13 of the Vehicle off the Road Procedure OP/44.

There are frequent requests for observers to accompany ambulance crews on A&E or Patient Transport Services (PTS) vehicles. Approval for observers on either A&E or PTS vehicles can only be authorised once the procedures laid out in TP/ 014 'Procedure for Ambulance Observers' have been followed.

- When such arrangements have been approved, the observer, regardless of their status, qualifications and training must not become involved in the care and treatment of patients unless specifically requested to do so in an emergency by ambulance staff
- Observers should be clearly identified by wearing an LAS fluorescent jacket marked 'Observer'.

Injuries or illness related to the workplace are covered by specific Health and Safety legislation. This is normally reported to the Health & Safety Executive (HSE) under RIDDOR guidance. However ambulance attendance to a workplace for life changing, life threatening or fatal accidents should be reported to the police as soon as possible via EOC. The police may need to instigate criminal investigation and/or notify HSE investigators. This section also applies to members of the public or non-employees in a workplace setting. The following are examples of workplace incidents that should be reported to the police at the time of the accident;

- fatal accidents
- amputation and/or multiple trauma
- loss of sight or serious eye injury
- injury resulting from an electric shock or electrical burn leading to unconsciousness, or requiring resuscitation or admittance to hospital for more than 24 hours; serious illness and/or unconsciousness caused by asphyxia or exposure to harmful toxin, chemical, biological or radiological substance. Any other injury deemed to be serious and necessitating prolonged hospital care/intervention.

10. Appropriate Clinical Care of Patients

All staff must act within their own professional boundaries recognising when to, assume responsibility from a lower qualified colleague and when to hand over responsibility to another senior professional colleague, as per TP/03 Statement of Duties to Patients. The highest clinical grade on scene takes overall responsibility for patient care. This however can be superseded by the arrival of further assistance e.g. a paramedic arriving after an Emergency Medical Technician crew or a pre-hospital physician arriving to assist a paramedic. Careful consideration must be taken when delegating clinical responsibility to a lesser qualified colleague – clinical primacy in the pre-hospital phase of care is

retained regardless of delegation. This clinical primacy is maintained until hospital handover, appropriate referral, leaving the patient in the care of a responsible person (see appendix 1) or valid refusal of assistance. If multiple members of staff are on scene of the same clinical grade – the first person engaging the person in clinical care, the attendant, assumes responsibility.

Early consideration should be given to further specialist resources required at scene. Requests should be made, where appropriate, for HEMS, BASICS or Clinical Advice via EOC.

The destination of the patient must be determined using criteria based upon clinical needs. Having addressed all matters of initial scene safety, attending staff must make a full assessment of the patient before determining where the patient will be taken. This will comprise of a primary survey, along with due consideration to the mechanism of injury where indicated. However, it is recognised that the detection of any time critical problems may require the assessment to be aborted, enabling the crew to commence rapid transportation with appropriate treatment en-route. Equally, situations involving patient entrapments or delays in removal from scene may require the summoning of additional clinical resources and/or other emergency services to the incident. Subsequent management of the patient will include the continual reassessment and correction of any primary survey problems, together with a comprehensive secondary survey where circumstances permit.

The most senior clinician on scene will consider both the clinical needs of the patient and the facilities available at local hospitals. These factors may influence the choice of destination. Where a designated destination has been provided, the patient must be conveyed to the precise destination stated upon receipt of the call details. Should subsequent assessment reveal a change in treatment priorities, the initial destination choice may be revised in the best interests of the patient. EOC should be informed of this and efforts should be made to inform the booking the clinician. Assistance can be obtained from the Clinical Support Desk/ Clinical Coordination desk in EOC regarding most appropriate place of care. This decision should take into account the wishes of the patient, for example a patient in an ‘end of life’ care phase where a non-acute setting may be appropriate as their preferred place of care.

Staff must ensure that all clinical assessments are undertaken in accordance with their training. These are detailed in the current JRCALC Clinical Practice Guidelines, as well as within the IHCD Basic and Paramedic Training manuals. Copies of these reference sources are provided on a personal issue basis to staff in accordance with their respective grade. Consequently, staff with queries on any aspect of this material are encouraged to seek assistance from their Team Leader, Complex Training Officer/ clinical tutor, or any member of the training department.

The LAS Assignment Record and Clinical Record Form (LA4) specifies the minimum level of observations to be performed on each patient. Additional observations and comments can be added in the free text box. Further supporting information can be obtained from the Patient Report Form User Guide, which is available via *'the pulse'* under 'Patients' and 'Assignment Record and Clinical Record Form'

Patients attended as the result of emergency calls may be conveyed to the nearest appropriate Emergency Department. However there are some exceptions to this:

- where the nearest/local Emergency Medicine Department does not receive a certain category of patient, e.g., paediatrics, these patients must be conveyed to the next appropriate Emergency Department.
- when the condition of the patient suggests that rapid access to specialist care will require that they be directly conveyed to a hospital providing that speciality, e.g., Major Trauma Centre, Hyper Acute Stroke Unit or Heart Attack Centre.
- maternity patients should be managed according to current JRCALC guidance and, where appropriate, local arrangements.
- patients whose condition justifies the use of an alternative referral pathway, which could include conveyance, to a minor injuries unit, Urgent care Centre, Walk in Centre or non-conveyance and referral to a pathway available in the community for example arranging for a district nurse to visit or other primary healthcare practitioner.

(The Clinical Support Desk/ Clinical Coordination desk in EOC can assist crews with the availability of pathways in specific geographical areas.)

Patients receiving ongoing treatment for a condition may be conveyed to the hospital where their regular treatment is provided on the provision that a more serious or life-threatening clinical condition does not take precedence (see 18.3). EOC or the urgent operations centre must be notified of on-scene requests for conveyance to a destination other than the appropriate Emergency Department. In all such cases, staff must ensure that the best interests of the patient are assured, and no significant clinical risk arises. The PRF should be filled out in accordance with the PRF user guide.

A Doctor or other Health Care Professional (HCP) with responsibility for the patient may make a request for the patient to be taken to a designated destination other than the nearest Emergency Department. Staff should

comply with the request, if clinically appropriate and safe, informing EOC/ UOC before leaving scene, and recording the name and details of the doctor/HCP on the PRF (LA4).

Where reasonable a patient or their relative's choice of destination should be taken into account and where possible complied with. Staff will need to be sympathetic to such requests while appreciating that taking patients to more distant destinations may have a negative impact on the ability to provide emergency cover for the local area.

10.1 Caring for Children

A child is defined in the following section as a person under 18 years of age. This is defined from The Children Act 1989.

It is good practice for a parent/guardian to accompany a child to hospital and ambulance staff should make every effort to ensure that this happens. When this is not possible, either a teacher or other responsible adult can accompany the patient. If this is not possible the patient may travel unaccompanied with the ambulance staff. If the child is travelling unaccompanied EOC must be informed and document this on the call log. Staff must obtain as much information about the patient as possible including relevant medical history to ensure a full hand over on arrival at the hospital. Emphasis must be placed at clinical handover to the hospital clinician that the child is accompanied and any details of where the parent or guardian may be should be handed over. This should be clearly documented with a name and signature on the PRF.

Before examining or treating a child ambulance staff must gain consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Children under 16 years of age have the right to provide independent consent proportionate to their competence (although their parents will ideally be involved). In cases where children do not have the capacity to consent for themselves, parents or someone with parental responsibility must give consent on the child's behalf. If the situation is deemed life threatening and the parent/ person with parental responsibility is not available the attending ambulance crew must act in the patient's best interest. If a competent child consents to treatment, a parent cannot override that consent. Legally, if a competent child refuses treatment a parent/person with parental responsibility may override that decision – see also OP/ 031 Policy for Consent to Examination or Treatment for more information.

If the removal of a patient to hospital will result in a child being left unsupervised, ambulance staff must either convey the child/children or contact EOC to arrange for the police to attend and assume responsibility. This action should not delay the patient's conveyance to hospital. If the patient's condition is serious and children are to be left alone, then the urgency for the police attendance must be indicated.

There is no minimum age at which a child may be left unsupervised. Legally, no offence is committed until the child comes to harm, at which point the responsible adult or parent can be prosecuted for failing to ensure their safety. As a guide, the following points should be considered

- If a child is under fifteen years, staff should make arrangements as per section 16.4
- Children between fifteen and eighteen years may be temporarily left alone if staff are confident of the child's ability to care for themselves. If in any doubt staff may make arrangements as per section 16.4. If a child is left at home the receiving clinician must be notified at hand over and the occurrence documented on the PRF and the EOC log.

If an unrelated adult, e.g. a neighbour offers to take responsibility for the children, and the patient or person with parental responsibility is not able to approve the arrangement then ambulance staff must inform EOC to request police attendance according to section 16.4.

11. Removal to Ambulance & Manual Handling

Patients must be removed from scene to the ambulance using the most expedient route and method available based upon their clinical needs. While recognising the core mobility classifications listed below in 14.4, it is essential that staff constantly reassess the patient's condition to ensure the method of removal is compatible with minimising any risks for the patient.

In particular, there are many conditions that have potentially serious implications, e.g., chest pain, for patients who for example, feel they are being helpful in volunteering to walk to the ambulance. In such cases, staff must use their skills in gently explaining the potential harm that can arise from such situations, and persuade the patient to comply with the treatment regime provided by the crew.

Staff must ensure that all efforts are made to protect the privacy, confidentiality and dignity of their patients. These not only reflect the rights of patients as individuals, but treating all patients with courtesy and

consideration significantly helps them to feel safe and secure. Similarly, attention given to the positioning and comfort of patients during the removal and subsequent journey only adds to enhance the overall patient experience.

For the purposes of mobility classification, patients conveyed by the LAS are categorised as one of the following:

Stretcher – patients who must be carried to and into the ambulance, and who are required to travel on the trolley bed.

Chair – patients who must either be carried to and into the ambulance, or who can walk to and into the ambulance with the assistance of two staff, and who may travel in a sitting position.

Walking – patients who require no assistance, or the assistance of one member of staff to walk to and step up into the ambulance, and may travel in a sitting position.

Staff must determine the mobility classification of emergency patients based upon their clinical assessment, and the requirements of current clinical protocols and guidelines. Once again, the potential risks for patient harm caused by inaccurate and inadvertent patient/ staff actions (as highlighted in 19.2) cannot be overemphasised.

Where a mobility classification has already been determined, e.g. non-urgent journeys, that classification must be adhered to as the minimum requirement. Where there is a significant discrepancy between the classification given and the assessed clinical needs of the patient, details should be noted on PRF.

Patients with mobility aids should be allowed to use and take these with them if they so wish and if deemed appropriate by staff (see 19.1). Patients in wheelchairs must be transferred to a fixed seat or trolley bed once on board the ambulance, and if the wheelchair is to be taken it must be safely stowed.

Non-emergency patients who are required on clinical grounds to stay in their wheelchairs during conveyance will only be conveyed in an appropriate vehicle with floor clamps, and a safety harnesses used to secure the patient.

Should a patient be reluctant or unwilling to allow staff to comply with the mobility classification that is relevant in their case, staff must make determined and tactful attempts to persuade the patient to comply.

Should a patient continue to act against the advice given, EOC should be informed at the earliest convenient opportunity, and the details recorded on the PRF. This information should also be included in the handover to staff at the receiving destination. All efforts must be made to ensure that any potential clinical risks that are a result of the patient's actions contrary to advice are kept to a minimum.

Ambulance staff should undertake a risk assessment of the situation in which they find their patient. If they estimate any factors to be beyond their capabilities then the assistance of a second ambulance crew or other services should be sought.

The rear suspension of the vehicle should be lowered when loading and unloading patients. Walking patients should use the hand rails provided to assist themselves into and out of the vehicle. Ambulance staff will need to give additional guidance if the person is injured, disabled, hard-of-hearing or has impaired sight.

Ambulance staff can request assistance from responsible personnel such as police officers, nursing and porter staff and members of the public but they must give clear and concise instructions and not ask them to undertake any activity that is obviously beyond their capability or which they are reluctant to do.

Staff should use, where appropriate and where training has been undertaken, all available lifting aids supplied by the service. If other lifting equipment is available on scene, for example, hoists, consideration should be given to allowing only the persons trained in use of the equipment to assist in the lift.

Ambulance staff called to attend patients in Care Homes are duty bound to fully examine, assess and treat appropriately. If it is necessary to lift the patient, staff should seek alternatives to manual handling such as hoist and slides if suitably qualified persons are present.

If patients in Care Homes are found to be uninjured the responsibility for lifting should be passed back to the Care Home staff.

12. En route to Destination

Note **– OP020** Contains further detailed advice on the transportation of patients, in particular mental health patients, and those patients where the assistance of the police is required.

In order to give maximum protection to patients and escorts whilst on Service vehicles, every effort must be made to ensure that seat restraints are used. Patients and escorts who decline to wear seat restraints should have their attention drawn to the notice displayed. If they still decline, a reference to this must be recorded on the reverse of the PRF and wherever possible a signature should be obtained. Attendants must wear seat belts in the rear of ambulances, unless to do so would hinder their ability to care for the patient. The legal responsibility for ensuring that a child under the age of 14 is restrained in the back of the ambulance, where it is possible to do so, rests with the driver.

The attendant must travel in the back of the ambulance with the patient. If a number of health care professionals are escorting the patient, the attendant may travel in the front of the ambulance, but must be prepared to assist the escorting team if required. The person with clinical primacy must remain with the patient or suitably delegate this responsibility.

The decision as to how many friends or relatives travel with the patient rests with the crew, and must be based upon both the patient's needs and the practicalities of the patient's treatment. When allowing escorts to travel with the patient, consider the following factors:

- Maximum loading on the vehicle, including patient and ambulance staff must not exceed the legal maximum for the vehicle.
- Escorts who are themselves distressed may have an adverse effect on the patient,
- Ambulance staff safety is paramount – escorts who appear drunk/disorderly may compromise that safety (especially if two or more). Equally, refusing an escort may aggravate the situation and will require careful judgement by the crew,
- If the patient is in cardiac arrest, or arrest is imminent, a relative/ close friend may benefit emotionally from witnessing that everything possible was being done. If the decision is taken not to convey the relative/ close friend with the patient, consideration should be given to arranging alternative transport.

If the attendant decides not to allow escorts, this message should be conveyed with sensitivity, tact and diplomacy.

Wherever possible the PRF should be completed whilst en route to hospital. If this cannot be achieved then the PRF should be completed as soon as possible on arrival at hospital. In the event that a FRU has attended the call prior to an ambulance, a copy of the single responder patient handover record should be given to the crew conveying the patient so that it forms part of the overall patient record. (See also Section 13.6)

In some situations clinical care and handover precedes completion of the PRF, particularly where patients are time critical if this is the case the PRF should be completed as soon as possible and then left with the receiving clinician to form part of the patient's record.

13. Pre Alert Call

In line with the Joint Royal Colleges Ambulance Liaison Committee National Clinical Guidelines if the patient's clinical condition warrants it a pre alert call should be placed to the receiving unit to notify them of the patient's arrival.

The JRCALC National Clinical Guidelines along with local guidelines provide advice as when to place a pre alert call.

The pre alert call should be structured using the CASMEET mnemonic

Call Sign
Age of patient
Sex of patient
Mechanism or injury or Mode of Illness
Examination (AVPU/GCS, RR, HR, SpO2, BP)
Estimated Time of Arrival
Treatment given

If undertaking a “Critical” inter-hospital transfer a pre alert call should be placed to notify the receiving unit that the patient is now on their way.

The use of the pre alert call should not be based on the physical distance from the hospital but on the clinical condition of the patient.

When placing a pre alert call the crew should proceed to hospital under emergency conditions (blue lights) as per TP/23 Driving and Care of Service Vehicles, Collision Reporting, Investigating and Adjudication.

14. Actions at destination

Upon arrival at the destination the patient should be removed from the ambulance using the most appropriate and safe means for their clinical condition.

A clinical hand over of the patient should be given to the Health Care Professional taking responsibility for that patient using the PRF to provide structure and clarity of the information provided.

The patient’s privacy must be maintained at all times. Ideally the handover should not take place in a public area.

Once the clinical hand over is complete, the receiving clinician should retain a copy of the PRF. At this point responsibility for the patient is transferred to the receiving health care staff.

Ambulance staff should also hand over any other relevant information regarding the patient’s circumstances – See Section 5 Patient Welfare and Section 6 Patient Protection for details.

It is the responsibility of the hospital to ensure that their administrative process is fulfilled. Ambulance staff will leave the PRF with the hospital in the pre-arranged location, but should not be involved in the generation of the

hospital patient record. LAS Staff should not carry out a verbal handover to reception staff, enter details on the hospital computer, or source the patient's hospital notes.

It is critical that the copy of the PRF is clearly legible. Staff should use a black ball point pen; press on a firm surface and sufficiently hard. If this copy is not legible, it should be over-written before being handed in.

Ambulance staff should inform the EOC as early as possible of any potential delays as a result of the patient's condition. Any other delays should also be reported to the EOC at the time of the delay (not retrospectively. A note will then be added to the electronic call log and this should also be documented on the PRF. Actions taken to mitigate and reduce such delays should also be recorded. EOC must be informed of any 'at hospital' delays exceeding 15 minutes.

It is essential that ambulance staff ensure their availability is reported promptly to the EOC after patient hand over by the use of the 'green mobile' status button. After reporting their availability to the EOC, the ambulance crew may request to remain on active area cover at the hospital and avail themselves of local facilities. This is acceptable providing they remain immediately available to respond to a call.

All non-disposable equipment and blankets taken with the patient should be retrieved, where possible, before leaving. This may be achieved by a direct swap. In the event of any essential equipment being left this must be documented on the PRF and EOC staff informed. All equipment must be identifiable to the LAS. Any equipment not retrieved by the end of the shift must be verbally reported to the oncoming crew and documented in the station Occurrence Book. Every attempt must be made to retrieve the equipment during the course of the shift.

15. Conveyance to a pre-designated ward or department (not Accident and Emergency (A&E), or other Emergency Referral Units)

The London Ambulance Service NHS Trust conveys both acute and non-acute patients during the course of its work. The vast majority of these are conveyed to Accident and Emergency (A&E), or other Emergency Referral Units. However there are some cases, where requests are made to transfer patients to a pre-designated ward or department. In these instances the needs of the patient must remain paramount until responsibility for care has been properly and safely transferred; there is a need to be mindful of the impact on service delivery caused by excessive delays.

If ambulance staff have concerns over the clinical condition of the patient at the pickup point or en-route, they should consider the need to pre-warn the designated unit, via EOC, of their arrival. These concerns may include the

circumstances in which they found the patient. Where appropriate, ambulance staff may request via EOC that a clinician is available to meet the crew on arrival.

There are situations when the patient's condition deteriorates, en-route, to the extent that in the ambulance staff's judgement it is deemed inappropriate to complete the designated journey. Should the decision be taken to divert to the nearest A&E, EOC should be contacted immediately to:

- pre-warn the A&E department via the CASMEET procedure,
- notify the unit previously expecting the patient,
- notify the referring clinician of the change.

Clinical escorts should be involved in this decision making process as appropriate.

When any transfer is booked to a non Accident and Emergency (A&E), (or other Emergency Referral Units) ward or department it is advisable for EOC to obtain the following information:

- the location of the unit,
- the reception point for the patient,
- where, out of hours, the entrance to the hospital/designated receiving, unit is locked. The method employed to gain access.

Where the patient is being conveyed out of hours and the entrance to the hospital/designated receiving unit is locked, ambulance staff should inform EOC of their pending arrival. EOC staff should contact the person on call in the hospital to allow for a member of staff to be ready to open the door

If A&E staff encounter any confusion with hospital staff as to the location of the designated receiving unit or how the patient should be conveyed to the unit, ambulance staff must take responsibility for conveyance. Any difficulties encountered should be documented (on the PRF) and ambulance staff should inform EOC on return the vehicle. EOC will inform the appropriate officer.

However before leaving any patient, ambulance staff must ensure that the medical / nursing staff at the designated receiving unit is informed of the patient's presence and provided with a hand over of the patient's condition

16. Patients not conveyed to a treatment centre

It is essential that ambulance crews make every reasonable effort to undertake a full patient assessment, treat and where indicated convey patients to the most appropriate facility.

When an ambulance has been ordered by another health care professional LAS staff must convey that patient to the agreed treatment centre. The only exception to this should if the patient is capacitant and adamantly refuses to travel to that

destination. In this situation the crew concerned must make every effort to speak with the health care professional who made the arrangements and discuss the case. If required further assistance must be sought via the Clinical Support Desk / On Call Clinical Adviser.

Ambulance staff should assume that in most cases conveyance is required. This may be to an ED, MIU, UCC or WIC. In some cases referral through an appropriate care pathway, for example a Falls Team or District Nursing Service may avoid the need for conveyance to hospital. If, after a full assessment, the patient is deemed to have a minor condition for which self care or self referral to another facility is deemed appropriate the patient should be advised of this.

Should non urgent conveyance to ED or an alternative facility be required then the attendance of an appropriate resource (eg A&E Support or PTS) should be organised through EOC / UOC. A copy of the PRF should be left with the patient.

Where a patient is reluctant to be conveyed to hospital, the clinical needs of the patient must determine the degree to which staff attempt to persuade the patient to travel. It is, therefore, essential that all patients are thoroughly assessed, and every appropriate effort made to persuade the patient to travel. It may be appropriate in these circumstances to take the patient to an alternative health care provider, e.g., Minor Injuries Unit.

Should a patient decline conveyance to hospital following ambulance assistance or treatment, staff should base their attempts to persuade the patient to travel upon their clinical needs. Where the patient continues to decline conveyance despite appropriate advice, EOC/ UOC must be informed and all relevant information recorded on the PRF. Where a patient lacks the capacity to make an informed decision crews may act under common law and in the best interests of the patient to affect conveyance in accordance with the Policy for Consent to Examination or Treatment (OP/31). Consider using the LAS form LA66 to assess best interests in a patient lacking capacity.

Dependent upon the circumstances and condition of the patient:

At a private address:

- The patient should be left in the care of a competent person (see Appendix 1) who has access to a telephone and details of the patient's GP. The crew should consider contacting the GP and advise the patient and their companion to recall the ambulance service if the patient's condition deteriorates. The white copy of the PRF should be left with a competent individual who should hand it to the patient's GP or other HCP.

- If there is no competent person to take responsibility for the patient, the crew must attempt to establish the name and telephone number of the patient's GP. EOC /UOC must be requested to contact the patient's GP, and will inform the crew of the GP's ETA.

In a public place:

- The patient should be left in the care of a competent person if possible. That person should be advised to take the patient home or to a place of safety, and to seek medical advice should the condition persist or deteriorate. The white copy of the PRF should be left with a competent individual who should hand it to the patient's GP.

- If there is no-one willing to take responsibility for the patient, and the patient is incapable of leaving the scene unaided, or concern is felt for the patient's welfare, the crew must request police attendance and await their arrival.

Staff should remain mindful that they can seek advice from EOC at any time, with further assistance provided by the Clinical Support Desk. The desk is staffed by experienced paramedics who have been trained to support staff with patient related clinical problems, as well as any aspect of patient assessment or treatment.

17. Advanced Decisions

An advance decision can be made by a patient in the event they are unable to consent for themselves or unable to communicate specific wishes regarding treatment they do not want to receive. An advance decision is binding if:

- The person making the decision was 18 or over at the time it was made and had the necessary capacity
- It specifies the specific treatment to be refused and the circumstances in which the refusal is to apply
- The advance decision has not been withdrawn at a time when the patient still had the capacity to do so.
- A lasting power of attorney has not been appointed since the decision was made.

Advanced decisions can be oral or in writing, however it will only apply to life sustaining treatment if it is in writing, is signed, witnessed and contains a specifically worded statement that it is to apply even where there is a risk to life.

In an emergency or where there is doubt about the existence or validity of an advance decision, treatment can be provided that is immediately necessary to stabilize or to prevent deterioration until such a time that the existence of the advance decision can be established. Consider using LAS form LA67 to assess the validity of Advanced Decisions.

18. Care of the Dying

On occasions patients who are dying, make a statement which could be relevant to:

- Their cause of death.
- The circumstances of their death.
- Personal wishes at the time of death, possibly concerning property or their feelings.

This constitutes a dying declaration and the information may be used in court if the patient's death is connected with an illegal act. If a patient knows they are dying and makes a statement, ambulance staff should write down where possible, what was said and the patient should sign the declaration. Any declaration must be given to the police along with a statement from the ambulance staff concerned.

An ambulance may be called to a terminally ill patient where death has occurred or is imminent. A decision may have been made by either the patient and/ or the patient's medical team that resuscitation should not take place this is commonly referred to as a DNAR (now sometimes being called a DNA-CPR) indicates that a decision has been reached and that resuscitation should not be undertaken. This can be for a number of reasons including but not limited to the clinical futility of resuscitation or a patients expressed wishes. The actual DNAR form does not necessarily need to be seen by the ambulance but the crew should be sure beyond reasonable doubt that a valid DNAR does exists. For example a DNAR maybe held in EOC by the clinical support desk or the crew have requested further details from another Health Care Professional that a DNAR exists these are situations where the actual DNAR may not need to be seen. However the existence of a DNAR should be based on more than a simple statement by the relatives of a patient that one exists.

Details of the DNAR may have been passed to the crew via the mobile data terminal or by radio message if the Do Not Attempt Resuscitation (DNAR) order or end of life care information has been received by the Clinical Support Desk in EOC. Equally information may exist in the patient's house. Specific instructions or medications should be utilised to ensure the patient has a comfortable and dignified death in their preferred place of care (often their own home). Early access and communication with the Clinical Support Desk when attending a patient for unscheduled care in the palliative or terminal phase can be provide additional advice and support.

A DNAR can be in a number of forms such as a specifically designed form, a

letter from the supervising clinician or an entry into the patient's notes. The ambulance crew should confirm that the DNAR is for the named patient and that if a review date has been stated that the form is within date. It should be noted that not all DNAR's will have a review date on and they should be considered indefinite.

Uncommonly, some patients for whom a DNAR decision has been established may develop cardiac or respiratory arrest from a readily reversible cause such as choking, induction of anaesthesia, anaphylaxis or blocked tracheostomy tube. In such situations CPR would be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances.

A DNAR relates purely to cardio pulmonary resuscitation CPR and does not effect other treatment. Although staff should consider any underlying conditions and if appropriate seek advice regarding the most appropriate treatment for the patient.

When a patient's death is expected due to terminal illness resuscitation does not have to be commenced or continued. As stated in the JRCALC clinical guidelines. In this situation sufficient evidence must be available to support this decision making process e.g. notes, end of life care drugs, communication with other health care professionals. Confirmation can be received verbally on scene or remotely by telephone. The Clinical Support Desk in EOC can assist with gaining this information or assisting in the decision making process, possibly involving the on call senior clinical advisor. In all instances of ambulance staff being present when death occurs, even if the death is expected, an LA3 ROLE form must be completed.

If the patient has seen their own General Practitioner (GP) in the 14 days preceding death, the GP may feel they can issue a medical certificate for the cause of death (MCCD). If the patient's own GP is unavailable contact the Out of Hours GP, District Nurse (DN) or Specialist Palliative Care Team (SPCT) caring for the patient and request their attendance. If GP, DN or SPCT are unavailable to assist then the police should be contacted. This should be viewed as the last possible option in an expected death situation. A completed copy of the PRF and the LA3 must be handed to the attending GP/ DN/ SPCT nurse or police officer. The LAS crew may then leave the scene. In situations where there is a responsible adult on scene who can remain until the arrival of the relevant health care professional refer to the procedure outlined in paragraph 14.2. In all of the above care of the dying situations, the Clinical Support Desk can be contacted for specialist advice.

18.1 Unexpected death at a home or place of residence

When an unexpected death occurs at home or place of residence, the attending ambulance crew must complete form LA3. The crew must contact EOC to request the attendance of the police. The police must be informed of all unexpected deaths as it is their responsibility to establish if the death is suspicious and to liaise with the Coroner's office. The Coroner must be informed of all deaths in their jurisdiction, however not all deaths will result in an inquest. A copy of the completed PRF and LA3 must be handed to the attending police officer and the advice leaflet should be offered to the bereaved. LAS staff are then free to leave scene.

In situations where there is a responsible adult on scene and the crew feel in their professional judgement they are in a position to leave that person with the deceased the person's name must be documented on the PRF and the LA3. A copy of each must be handed to the person and they must be instructed to hand the documentation to the attending police officer. The crew must be absolutely confident that this process will be followed before leaving scene. On leaving scene EOC must be informed of the crew's actions and the name of the adult left at the scene.

Patients who are recognised as deceased on private premises must not be removed by the LAS. **Under no circumstances should a deceased patient be removed from the scene without authority from the Coroner.**

18.2 Unexpected death in a public place.

Once ambulance staff have recognised life to be extinct copies of the completed PRF and LA3 must be handed to the attending police officer. If the police are not on scene their attendance must be requested via EOC. All efforts must be made to conceal the body from public view. LAS staff must remain on scene until the police are in attendance, once the relevant information and documentation has been handed to the attending police officer the crew are then in a position to leave the scene.

It is not the responsibility of the LAS to remove deceased patients from scene. In **exceptional** circumstances and only when the attending police officer has liaised with the Coroner's Office, LAS crews may assist in removing the deceased to a public mortuary. The destination of the patient will be determined by the Coroner's office. **Under no circumstances should a deceased patient be removed from the scene without authority from the Coroner. An individual police officer cannot authorise the removal of a deceased patient, only a Coroner or Coroner's officer can do this.** If an LAS crew have been asked by a police officer or doctor to remove the deceased from scene,

assurance must be sought to ensure that the Coroner has been informed and document on the PRF and LA3 the shoulder number of the police officer authorising the removal and the name of the Coroners Officer authorising it.

18.3 Death in unusual or suspicious circumstances

Ambulance clinicians cannot determine whether a death is suspicious or not. When requesting police assistance it should be defined as expected or unexpected. However, when unusual or suspicious circumstances are present all reasonable precautions to preserve the potential crime scene should be taken. Any findings, observations or disturbance to the scene prior to police arrival should be documented and handed over to the relevant police officer.

18.4 Sudden unexpected death of an infant

In the event of being called to attend an infant (under 2 years of age) the following applies:

- Resuscitation should always be initiated unless clearly inappropriate.
- In cases where active resuscitation is not taking place and life has been recognised extinct, the infant must still be conveyed to an A&E department that accepts paediatrics. The hospital must be alerted in the usual manner. This will facilitate early examination by a Paediatrician.
- Infants must **not** be conveyed directly to the mortuary.
- Only in cases of severe trauma or decomposition should the infant be left on scene. Under these circumstances the crew must remain on scene and the police must be asked to attend.
- If significant concerns are raised at any stage about the possibility of abuse or neglect, a decision may be taken for the police to become the 'lead agency'. The police should be informed immediately that significant suspicion arises to ensure any further interviews with the family accord with the requirements of the Police and Criminal Evidence Act 1984. The LAS policy for children and vulnerable adults may also be of use in these circumstances.
- Keep the parents informed of your actions.
- A Child at Risk/ in-need Report Form (LA279) must be completed for all children at the scene at the time of the death; this is to ensure the welfare of those children. One form must be completed for each child at the scene whether they are related to the deceased infant or not.

- In cases where the infant is conveyed to hospital the name of the hospital clinician who receives the hand over must be clearly documented. In the rare situation where the infant remains on scene the shoulder number of the police officer in attendance must be recorded in the appropriate place on the PRF.

- A LA3 Recognition of Life Extinct (ROLE) form must be completed and handed to the hospital clinician or police officer.

18.5 Sudden unexpected death of a Patient aged 2-18

In the event of attending the unexpected death of a patient aged 2-18 years old, the following applies:

- Standard ROLE procedure should occur as per JRCALC clinical guidance. The patient should not be moved from scene without permission of the Coroners officer – see section 19.3 & 20.1.

- Keep the parents informed of your actions.

- A LA3 ROLE form must be completed and handed to the relevant police officer on scene.

- LA279 must be completed for all children at the scene at the time of the death to ensure the welfare of those children. One form must be completed for each child at the scene whether they are related to the deceased child or not.

- If significant concerns are raised at any stage about the possibility of abuse or neglect, a decision may be taken for the police to become the 'lead agency'. The police should be informed immediately that significant suspicion arises to ensure any further interviews with the family accord with the requirements of the Police and Criminal Evidence Act 1984. The LAS policy for children and vulnerable adults may also be of use in these circumstances.

A DSO should be sent to all deaths of a patient under 18 years old to ensure staff welfare and to support the above actions.

Sections 18.4 and 18.5 do not apply to the expected death of an infant, child or adolescent due to terminal illness. In most cases the Clinical Support Desk will be contacted in advance of a child entering the terminal phase of life due to a life limiting illness in order for patient specific plans to be put in place. The Clinical Support Desk can always be contacted to assist staff with the clinical management of this patient group.

Further guidance can be found in the Medical Directorate bulletin – Sudden unexpected death in infants, children and adolescents dated 18th February 2009.
http://thepulse/uploaded_files/bulletins_other/medical_18feb09.pdf

Implementation Plan

IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse and to the public on the LAS website.
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document.
Training	The principles and practices contained within, or referred to via this policy are covered in the initial education and training of staff. Continuous professional development (CPD) education and training will be provided either by: - Formal CPD courses at a Training Centre - Complex Trainer/ Team Leader led events - Bulletins/ Clinical Update The precise method will be dependent upon the topic/ area being introduced/ revised, and will be advised by either the Education and Development Department and/ or the Medical Directorate.
Monitoring	Individual clinical staff will be monitored for adherence to this policy by CPI checks and Station Management Teams. Any problems identified will be referred to the AOM and/ or the Sector ADO as appropriate. The monitoring of the assessment, diagnosis and treatment regimes, according to JRCALC, will be carried out routinely through the PRF compliance audit by the Management Information Team/Clinical Audit Team. The team leader will be responsible for dealing with any noted deviation from the JRCALC guidance. Other auditing, including clinical performance indicators will also form part of this overall monitoring system. Where risks, failings or deviations from recognised clinical practice are identified through the monitoring of this policy an action plan will be created with clear timescales and communicated to relevant Leads. This action plan will be performance managed by the Assistant Director of Operations and reported by exception to the Clinical Quality, Safety and Effectiveness Group. The Training Services Group, under their respective terms of reference will monitor how this policy operates. The Trust Board will be informed of exceptions relating to this policy by the Medical Director's Report as appropriate or recommended by the Quality Committee at the earliest

	available opportunity.

Appendix 1

Definition of Responsible or Competent Person
(extract from TP/003 Statement of Duties to patients)

A competent or responsible individual is defined as:

One who is able to understand the information relevant to the decision.

One who is able to retain that information.

One who is able to use or weigh that information as part of the process of making the decision.

One who is able to communicate his decision by using any recognizable means of communication.

The factors that will determine that the individual is capable of looking after the patient are:

Has access to a telephone,

Knows the patient's General Practitioner's contact details,

Is able to communicate with the emergency services,

The greater the clinical risk of the incident, the greater the competency required of the person accepting responsibility for the patient and the lower the threshold for contacting other agencies. Only after confirming that the above criteria have been met should ambulance staff deem it appropriate to leave a patient in that person's care.