London Ambulance Service NHS Trust

# Policy advising staff where deviation from guidelines is considered

## DOCUMENT PROFILE and CONTROL.

**Purpose of the document**: is to ensure all staff supplying clinical care, be that by direct patient contact or otherwise, are aware of their responsibility to be able to justify and document any deviation from agreed clinical guidelines or protocols.

**Sponsor Department:** Medical

**Author/Reviewer:** Senior Clinical Advisor. To be reviewed by Oct 2011.

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| **Links to Related documents or references providing additional information** | | |
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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

This document cannot cover all situations where staff may make an assessment that indicates a deviation from clinical guidelines or protocols may be necessary. It can therefore not be stressed enough, that staff must seek guidance in situations where deviation is being considered. As a general guiding principle, staff must be able to demonstrate that they understood, considered, and as appropriate complied with and documented the guidance given in 4.2.1 below.

The core nationally agreed clinical guidelines are the Clinical Practice Guidelines for use in UK Ambulance Services published by the Joint Royal Colleges Ambulance Services Liaison Committee (JRCALC), (commonly called the "JRCALC guidelines"). They are updated on a bi-annual basis and have the endorsement of all the Royal Medical Colleges. They have also been accepted as a core clinical standard by the College of Paramedics – British Paramedic Association (BPA), the UK paramedic professional body. They are further included within the Approvals Procedure of the Health Professions Council (HPC) for any education and training course leading to registration with the HPC as a paramedic.

The JRCALC guidelines have been accepted as setting the base standard of care for clinical practice within the LAS. Modification by the LAS to the JRCALC guidelines and/ or other nationally agreed clinical guidelines and protocols may take place from time to time. Any such changes will always be endorsed first by the Clinical Steering Group, then the Clinical Governance Committee and ratified by the Trust Board. Staff will then be formally informed via a Medical Director's Bulletin and through any requisite education and training.

It is accepted that there will be occasions when it is not possible to comply fully with accepted clinical guidelines and/ or protocols. In these circumstances all staff are required to be able to justify and document any such deviation(s).

## 2. Scope

This policy and procedure applies to all clinical / medical staff within the LAS who supply direct clinical/ medical care to patients. It also applies where clinical/ medical advice is being given via the telephone, R/T system or other method(s) of communication (written, e-mail etc…).

This policy and procedure needs to be taken into account by non-clinically/ medically educated and trained staff who have managerial responsibility for clinical / medical staff.

## 3. Objectives

To ensure all staff supplying clinical care, be that by direct patient contact or otherwise;

1. Are aware of their responsibility to be able to justify and document any deviation from agreed clinical guidelines or protocols.

2. Know how and where to seek advice and guidance before any deviation from agreed clinical guidelines or protocols is undertaken.

3. Know how and where to document any deviation from agreed clinical guidelines or protocols.

4. Responsibilities

4.1 The Clinical Steering Group and the Clinical Quality, Safety and Effectiveness Committee are responsible for agreeing local clinical guidelines and protocols.

4.2 LAS managers are responsible for supporting staff in their decision making process

4.3 It is the responsibility of all LAS clinical and medical staff to understand that they must act within their own personal scope of education, training and practice.

4.4 Registered medical practitioners, paramedics and other Allied Health Professionals are reminded that they are also obligated to any standards of conduct, performance and ethics, and standards of proficiency laid down by their regulatory body.

## 5. Responsibility of all LAS clinical / medical staff to act within agreed clinical guidelines and / or protocols

5.1 The core agreed clinical practice guidelines in use by LAS will be those published by JRCALC (as amended). All front line staff will be given both an A4 format of the JRCALC guidelines and a smaller pocket book sized version of the JRCALC guidelines. It is the pocket book version that all front line clinical staff must carry with them at all times when on duty.

5.2 The JRCALC Guidelines are regularly updated and any such updates will be communicated to staff via Medical Director's Bulletins, the issuing / re-issuing of complete A4 format books, the pocket books and / or inserts for these. Where required additional education, training and assessment (where necessary) will be delivered.

5.3 The core JRCALC guidelines are supplemented by local LAS clinical guidelines and protocols from time to time. An example is the LAS protocol for the direct admission of patients for primary coronary angioplasty. All such local clinical guidelines and protocols will be agreed by the Clinical Steering Group and the Clinical Governance Committee. They will then be communicated via Medical Director's Bulletins, Education and Training Bulletins, formal Education and Training Sessions and / or other methods as deemed appropriate by the Medical Director.

5.4 It is the policy of the LAS to allow staff to deviate from agreed clinical guidelines and protocols under the procedure laid out in Section 4.2 below.

## 6. Procedure to be followed by staff when deviating from agreed clinical guidelines or protocols.

6.1 When staff are faced with a situation where it is believed a deviation from agreed clinical guidelines or protocols is required, they must be able to demonstrate that:
They have primacy of care for the patient.
They understand the clinical, physical, procedural and legal implications (ie consent, best practice and competence) of deviating from agreed guidelines or protocols in the circumstances with which they are faced.
Where at all possible they have sought advice from a colleague where appropriate, and / or;
They have sought advice from their Team Leader / DSO or AOM if appropriate, and / or;
They have sought advice from the Clinical Support Desk via EOC, or the On Call Clinical Advisor.
All decisions are fully documented as a minimum on the PRF – See further guidance detailed at 5.1.

6.2 The principle that must be adopted is that the greater the deviation from clinical guidelines or protocols being contemplated, the greater the level of advice and guidance that must be sought. Thus a decision not to dress a minor wound could be documented on the PRF with reasons with no recourse to seeking advice being taken. But a decision to use a higher dose of a particular drug than allowed under JRCALC guidelines must be clearly documented on the PRF with a narrative of who that decision was discussed with. In this set of circumstances it expected that as a minimum the Clinical Support Desk where contacted via EOC and the patient discussed.

Staff are also encouraged to seek the attendance of other clinical staff and / or LAS managers at scene to assist them in the decision making process, particularly where consideration of a more serious deviation and / or implications may occur. The On Call Clinical Advisor can also be contacted 24 hours a day via EOC, and can in the first instance speak directly to the member of staff concerned either by telephone or R/T patch.

6.3 In addition to the PRF, staff may also wish to complete an LA52 under the LAS Incident Reporting Procedure.

**Implementation Plan**

| **IMPLEMENTATION PLAN** | |
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| **Intended Audience** | All clinical staff |
| **Dissemination** | Available to all staff on the Pulse<br><br>All clinical staff to be given a copy on commencement |

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| | employment, be that at the start of initial education and training, or on transfer from another employer. |
| **Communications** | Revised Procedure to be announced in the RIB and a link provided to the document.<br><br>Direct communication by Managers and Tutorial staff. LAS website, Medical Directors Bulletins as appropriate. |
| **Training** | Continuous throughout core clinical education and training, and also via CPD activity. |
| **Monitoring** | Variances in treatment/ decision making outside JRCALC and local procedures may be identified via the Clinical Performance Indicator process (CPI), the Incident Reporting System or the Clinical Support Desk.<br><br>The CPI process and the Incident reporting Process feeds into the Clinical Quality, Safety and Effectiveness Committee so any trends will be identified and acted upon via that committee under its Terms of Reference.<br><br>The Clinical Support Desk compiles reports on the type of advice that is being given by the CSD staff. This is reported to the Senior Management Group and thus trends will be identified and acted upon via the SMG under its Terms of reference.<br><br>Where policy or other guidance needs to be changed or organisations such as JRCALC informed then that will be managed under the guidance of the Medical Director, and action plans / outcomes reported to the Clinical Quality, Safety and Effectiveness Committee. |