London Ambulance Service NHS Trust

Control Services - Call Taking Procedures

DOCUMENT PROFILE and CONTROL

Purpose of the document: To provide Control Services with agreed procedures to manage call taking arrangements.

Sponsor Department: Control Services

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OP061	Control Services – Dispatch Procedures	0.5
OP066	Use of Paper Operations with Control Services	1.3

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1. Introduction

The London Ambulance Service (LAS) attends a diverse range of patients, often in unique and demanding circumstances. The Emergency Medical Dispatcher (EMD) handling the call is, normally, the first point of contact in the whole patient care delivery and the patient experience can be influenced by the way this call was handled.

2. Scope

This procedure specifies the actions to be taken by EMD's when receiving emergency and non-emergency calls.

3. Objective

To ensure that all emergency and non-emergency calls received by the LAS are handled correctly, consistently and safely whilst ensuring that the level of patient care and service is optimal at all times.

4. Responsibilities

4.1 The **Chief Executive** has overall accountability for having an effective operational and risk management system in place and an effective system of internal control within the Trust. The day to day responsibility for risk and operational management is delegated to nominated directors.

4.2 The **Medical Director** has delegated responsibility for managing the strategic development and implementation of clinical management, clinical governance, and infection prevention and control.

4.3 The **Deputy Directors of Operations (North & South)** have overall responsibility for core operational delivery.

4.4 The **Head of Control Services** has delegated responsibility for managing risks associated within Control Services (CS), and has responsibility for the development of operational strategy in order to meet national performance and clinical targets.

4.5 **Ambulance Operations Managers** (**AOMs)** have responsibility for the day to day delivery of core services within CS.

4.6 **Operation Centre Managers (OCMs)** have tactical responsibility for the day to day delivery of core services and line management within CS.

4.7 **Emergency Medical Dispatchers (EMDs)** are responsible for triaging, and handling all calls received and dispatching resources to the patient. This can involve giving the patient/caller information to assist the crew on arrival or giving life saving instructions.

4.8 **Operational Staff** are responsible for the day to day delivery of core services.

5. General Principles

5.1 The EMD should remain empathetic and professional at all times whilst handling incoming calls. It is their responsibility to make a supervisor / manager aware if they experience difficulties as soon as possible and practical to ensure quality of service is not compromised.

5.2 The EMD should never question the validity of any request for assistance, or the integrity of the caller or of any information passed from the caller.

6. Paper Operations

6.1 Whilst Control Services is utilising paper operations (See OP66 Paper Operations) all of the procedures and protocols below should be adhered to at all times.

6.2 As stated in OP66, incoming calls should be recorded in triplicate on the requisite Call Receipt Form (CRF).

6.3 During paper operations EMD's must wait for a verbal handover from the telephone exchange with the incoming call details, and then the EMD must always use the opening phrase "Emergency Ambulance, what's the location of the incident".

7. Procedures

The following sections provide specific procedures needed for call taking.

1. Initial Details

1.1. For any 999/112 call to be connected to the LAS, the caller must have indicated to the Communication Provider (CP) Operator that an ambulance was required.

1.2. In every instance the EMD will determine the location of the emergency/incident by asking: "What's the address of the emergency?"

1.3. In every instance the EMD will determine a call back number for the caller by asking: "What's the phone number you're calling from?"

1.4. The EMD will always verify the location details and the call back number by asking the caller to repeat them.

2. Caller Line Identification (CLI)

2.1. The CLI location will be automatically placed in the location field and verified by the gazetteer.

2.2. If it is not an exact match to the CLI data, or the location of the call is different, the EMD will alter the information in the location field.

2.2.1. This will cause the gazetteer to search again in order to verify the new location.

2.2.2. If the CLI data is changed the vehicle may be taken to a point some distance from the call - and the response to the patient may be delayed.

2.3. If a gazetteer match is found, a secondary location is not required unless the address is a flat, a major/long road, or the location may be difficult to find (e.g. parks/open spaces etc).

2.4. If the CLI data does not generate a verified location in the gazetteer, the EMD should make necessary adjustments to this data as per issued guidance to facilitate the selection of a verified location and the event to enter in CAD.

3. No Caller Line Identification (CLI)

3.1. The EMD will type the location given in the location field and search the gazetteer for a location match.

3.2. Secondary locations must be obtained for calls where the gazetteer location is not found, where possible gaining a door number or junction road using the "@" to gain a precise map reference.

3.3. If the location is found by entering the full post code and house number, the EMD MUST STILL ask the caller for the address in full.

3.4. If unable to find a gazetteer match, the EMD must establish the location of the incident, using their map book, or any other available resource (eg NSY GS (general search) etc).

3.5. It is essential that the EMD log any gazetteer error by ticking the 'Q?' check box, and recording the relevant details in the 'CMT' field (or the 'Remarks' field if insufficient space in 'CMT' field).

3.6. **<u>If an EMD has difficulty finding a location, assistance must be sought from the Call Taking Manager (CTM) or Call Handling Supervisor (CHS)</u>**

4. Alarm Centres & 4th Party Callers

4.1. Where calls are passed from alarm centres/care lines the CLI information is likely to present with the patient's address and phone number.

4.2. EMD's **should not** change the origin phone number displayed as this shows the patient number.

4.3. The alarm centre number should be noted in the 'Transport Contact' tab.

5. Roaming Calls

5.1. It is possible to make a 999/112 call from a mobile phone that has no network coverage.

5.2. The mobile phone will "link" into the first available network signal it finds, regardless of network supplier.

5.3. These calls differ from normal mobile calls in these respects.

5.3.1. No customer telephone number will be automatically available.
5.3.2. It is highly unlikely the EMD would be able to call them back.
5.3.3. Any CLI details supplied will be "dummy" default network settings.
5.3.4. No mobile northings or eastings will be available.
5.3.5. It is not practical to trace calls – it can take up to two days.

5.4. The operator passing the call will identify it as a "Mobile Emergency Roamer with no customer number displayed".

5.5. The EMD will take the call in the usual manner.

6. Emergency Short Message System (SMS) Calls

6.1. Emergency SMS has been developed as an alternative for those who are unable to use the usual voice 999/112 service. It is meant for those with hearing or speaking difficulties who routinely use SMS, as an option in circumstances where a text phone is not available.

6.2. When a call is connected to the operations centre, the operator will identify it as an Emergency SMS text call.

6.3. The operator will stay on the line to ensure the connection is completed.

6.4. The EMD will continue to take the call in the usual manner; however, there are some **key points for EMD's taking emergency SMS text messages**.

6.4.1. Listen carefully to information passed by the relay assistant from the first text message; it might contain both location and incident details.
6.4.2. Ask the questions as if you are talking directly to the caller.
6.4.3. Ask no more than two questions per message.
6.4.4. Reassure the caller as soon as possible that answering these questions will not delay help. If help is already on the way tell them it is on the way.
6.4.5. Try not to ask for the same information more than once.

6.4.6. Ask for the postal area, street name or local landmarks, rather than for a postcode.
6.4.7. Be aware that these calls will take longer to handle as questions/answers exchanged verbally with the relay assistant have to be sent/received as standard SMS texts.

7. Text Relay

7.1. Text Relay has been developed as an alternative for those who are unable to use the usual voice 999/112 service. It is meant for those with hearing or speaking difficulties who routinely use SMS via real-time text terminals (textphones, minicoms) to contact the Text Relay emergency service.

7.2. When a call is connected to the operations centre, the operator will identify it as "..Connecting a Text Relay call from number…". The operator will stay on the line to ensure that the connection is completed.

7.3. The EMD will continue to take the call in the usual manner, however, there are some **key points for EMD's taking Text Relay calls** (as detailed in see 6.4.1. – 6.4.7.).

8. Voice Over Internet Protocol (VoIP) Calls

8.1. Using a fixed or wireless broadband connected to a personal computer (PC), service users are able to use a handset or headset, Personal Digital Assistant (PDA), mobile or a fixed telephone handset to make calls.

8.2. When the VoIP call is passed to the operations centre the operator will verbally identify that they are connecting a VoIP caller and pass the telephone number.

8.3. The EMD will document this and continue to take the call in the normal manner.

9. CLI and VoIP Calls

9.1. As this service allows users to move location, simply by logging onto their internet anywhere in the world, it enables them to make and receive calls with their home CLI.

9.2. It is essential, therefore, that the location of the incident is asked for and verified.

10. GPS Telematics Calls

10.1. Emergency calls may be transmitted from on board vehicle GPS units which can be either manually or automatically activated by vehicle sensor (airbag, bumper contact etc).

10.2. These units will send either voice or data (or a combination of both) to the operator who will contact the relevant Emergency Control as normal.

10.3. The operator will announce the call as a "GPS Telematic call" and pass the details they have.

10.4. This data could include, but not limited to:

10.4.1. Vehicle make/model
10.4.2. Vehicle registration number
10.4.3. Direction of travel
10.4.4. Eastings and northings.

10.5. If voice contact has been made there could be further details to pass.

11. ProQA

11.1. EMD's must complete all calls through ProQA limiting any free text to relevant crew safety information, patient care information and access information.

1. Connection

1.1 For any 999/112 call to be connected to the LAS, the caller must have indicated to the Communication Provider (CP) Operator that an ambulance was required.

1.2 It is recognised that in many cases the caller will not have English as their first language.

1.3 In such instances a third party language translation service may be used to assist the EMD in taking the details of the call and/or the any staff on scene with the patient.

2. 999/112 Calls and Ring Backs

2.1 The EMD will put the caller on hold, using the Conference Key, whilst connecting to the translation service, ensuring that they have fully explained their actions to the caller.

2.2 The EMD will conference the caller back into the call at the earliest opportunity especially where there is a comfort message being played in both languages.

2.3 The EMD will select 'Unknown' as the event type and enter "Unknown" in the remarks field.

2.4 The EMD will select MPDS protocol 32 (Unknown Problem) and code this call as 32B4 – caller's language not understood and update the event.

2.5 When an interpreter does come on line, and/or it becomes apparent what the problem is, the EMD will change to the most relevant MPDS protocol.

3. When connected to the Language Translation service:*

3.1 The EMD will identify themselves, to the interpreter, using the EVENT number as the LAS' identifier.

3.2 If no location has been identified at this stage the EMD will need to give their 4 DIGIT phone LOGIN PIN as the LAS' identifier.

3.3 If control is working under fall back conditions, the EMD will give their 4 DIGIT phone LOGIN PIN.

3.4 On rare occasions the LAS details fail to pre-populate the field on the translation service operator's terminal, the EMD will be asked for the customer ID number. ***This is held by the CTM.***

3.5 The interpreter's identification number must be recorded in the Remarks field.

3.6 The interpreter should be given a brief of the situation.

3.7 The interpreter should be asked to inform the caller that they are there to help both the caller and the EMD to communicate.

4. Statements

4.1 The statement to be made on initial contact with an interpreter is "**This is the London Ambulance Service with a 999 emergency call in progress. Please inform the caller that the answering of questions will not delay the help***".*

4.2 Users should conduct the call as though they were talking directly to the caller. This makes the interpreter's task easier, as they are simply translating what the EMD is asking.

4.3 Do not say **"*Can you ask if the patient is breathing"*;** the question should be **"*Is the patient breathing*"**.

5. Connecting VCS to Language Translation Service

5.1 VCS have access to the language translation service through their service communication device, and should normally make contact on their own.

5.2 If an EMD is requested to connect a crew on scene to the language translation service, the crew's call sign should be used as the LAS reference.

5.2.1 This should be recorded as supplement information in the Event Chronology, along with the language requested.

6. Issues

6.1 Ensure that any issues using the service are recorded via the reporting forms held by the CTM.

1. Introduction

1.1 For any 999 call to be connected to the LAS, the caller must have indicated to the Communication Provider (CP) Operator that an ambulance was required.

1.2 Silent calls to CPs are all directed to the police.

1.3 Any call that is therefore abandoned during the connection to us, or is a silent call, must be responded to.

2. Calls from Landlines

2.1 The location details as presented by CLI or verbally by the CP operator on abandoned calls must be noted in the Location field and the call must be rung back immediately.

2.2 The time and the outcome of the ring back is to be noted in the remarks field, and the Event must be updated.

2.3 At least two attempts should be made to reconnect to the caller.

2.4 If the call is answered it is to be managed and triaged through MPDS as appropriate.

2.5 If there is no answer but an answer phone is available, a message must be left, indicating that we have called, and for the caller to contact us if an ambulance is still required.

2.6 On silent calls or if on ring back there is no reply or an engaged tone, the call should be completed as an "Unknown Problem - please investigate" through protocol 32 and sent for sector to respond to. If, on arrival at the address/location there is no reply or no trace, OP/14 must be followed.

2.7 In the event no CLI location is known and the CP does not know any subscriber details the call should be quit in this manner:

2.7.1 **Unknown**, should be entered in the Location field.
2.7.2 Event Type **Aband** should be selected.
2.7.3 The Atom should be set to **CTM** in the Combined Override Panel.
2.7.4 **'Abandoned call – no dispatch OP/60 section C applies'** should be entered in the Remarks field and the Event must be updated.

3. Calls from Mobiles

3.1 Abandoned calls from mobiles should be rung back immediately and clarification sought as to whether an ambulance is required.

3.2 The time and outcome of the ring back is to be noted in the remarks field, and the Event must be updated.

3.3 If the number is engaged or diverts to voicemail on first attempt, a second attempt to contact the caller must be made.

3.4 Assistance must be sought from the CHS/CTM to identify if a call from the same origin number is in progress elsewhere in the EOC.

3.5 The CTM would use the ASQ (ANI/ALI record Query) form to search for the phone number.

3.6 If there is no answer, after two attempts to contact the caller, and voicemail is available, a message must be left, indicating that we have called, and for the caller to contact us if an ambulance is still required. The following can be used to relay this message;

"This is the London Ambulance Service calling in regards to an abandoned 999 request made from this number. If an ambulance is required then please ring us back immediately on 999 for further instructions. An ambulance has not been sent at this stage."

3.7 The event should be updated and closed as 2.7 (above). If for any reason the call handler decides to progress to a subscriber check they should seek authorisation from the CHS/CTM to do so. If the registered details are provided immediately the call handler should update the Event and proceed normally. Should an agency need to ring back to confirm subscribers details the event should be closed as per 2.7 and the CHS/CTM updated. The call handler should then be available for other incoming calls. On receipt of the call from the said agency the closed event should either updated due to a lack of subscriber's information, or re-opened and populated with subscriber's details so that an ambulance resource can be dispatched

3.8 If the call is answered it is to be managed and triaged through MPDS as appropriate.

3.9 If a silent call is received or the phone is answered on ring back but the patient cannot speak/speak clearly EMDs must immediately inform a CHS/CTM. They must:

3.9.1 Using the location information provided by the CP and translating those Easting's and Northing's into a map reference, establish the area from which the call is being made (triangulation).
3.9.2 Contact the CP to obtain subscriber details. If the two sets of information tie up, an ambulance should be dispatched to the subscriber's address and investigated.
3.9.3 If the mobile phone is unregistered or subscriber details are not known, provided a message has been left on voicemail the call may be processed as 'abandoned call'.

4. Public Telephone Kiosk

4.1 It is important that a potential patient is not treated as a hoax caller.

4.2 The location details as presented by CLI or verbally by the CP operator on abandoned public telephone kiosk calls must be noted in the Location field and the call must be rung back immediately.

4.3 The time of the ring back is to be noted in the remarks field, and the event must be updated.

4.4 At least two attempts should be made to reconnect to the caller. To avoid operator error, the telephone number is to be entered manually on both occasions.

4.5 If the call is answered it is to be managed and triaged through MPDS as normal.

4.6 If the call is silent or if on ring back there is no reply or an engaged tone, the call should be completed as an “Unknown Problem - please investigate” through protocol 32 and sent for sector to respond.

4.7 Where an abandoned or silent call is received from a mental health unit, contact should be made with a staff member to confirm if ambulance attendance is required. The contact attempt and outcome, including details of staff members spoken to is to be documented in the event chronology.

5. Urgent Disconnect / Demand Management Plan

5.1 During periods of high demand or at times when Urgent Disconnect has been implemented, the CTM/CHS may dedicate one member of staff to ring back all abandoned calls.

6. Subscriber Checks

6.1 The Regulation of Investigatory Powers Act 2000 (RIPA) provides the legal framework in which access to subscriber details may be obtained from CPs.

6.2 Under normal circumstances, the Code of Practice for the Public Emergency Call Service (PECS) allows the Emergency Authority (EA) to request subscriber details for the purpose of preventing death or injury or any damage to person’s physical or mental health or for mitigating any injury or damage to a person’s physical or mental health.

6.3 EAs may only request subscriber (caller name and address) details under the provisions of section 22 of the Regulation of Investigatory Powers Act 2000 (RIPA). Other than in limited circumstances it is necessary for Emergency Authority Control Rooms to obtain a notice under RIPA. This should not be necessary when seeking telephone subscriber details in order to respond to a call for emergency assistance.

6.4 CPs will only confirm or reiterate caller location information for up to one hour after the original emergency call without the need for a RIPA notice. Caller location information not previously supplied but would otherwise have been available can also be supplied for up to one hour after the original emergency call without the need for a RIPA notice. Use of the information is restricted to helping the EAs to respond to a request for emergency assistance.

6.5 If a third party can only provide a telephone number for a patient the agent is to make at least two attempts to contact the patient utilising the number provided. If unsuccessful, the call is to be referred to the OCM for the following actions to be completed.

6.6 The OCM is to contact the Metropolitan Police Service (MPS) control room supervisor on 020 7109 9100 and advise the supervisor that it is a life at risk issue/grade 1 RIPA request and you require the on call SPOC (Single Point of Contact) who can then ascertain subscriber details in these circumstances.

1. Coding

1.1. Any 999/112 calls, from the public, that are query meningococcal septicaemia (meningitis), or where symptoms of possible meningitis are given, should be triaged using MPDS Protocol 26 “Sick Person” and coded as 26A12 (possible meningitis).

2. Symptoms

2.1 Symptoms that may indicate that a patient is suffering from meningitis include, but are not limited to:

2.1.1 Rash that is non-blanching when a glass or finger is pressed on the rash – **this may develop rapidly.**
2.1.2 Constant headache
2.1.3 Severe ‘Flu-Like symptoms
2.1.4 Fever
2.1.5 Photophobia
2.1.6 Neck stiffness – touching their chest with their chin will be very painful or unachievable.
2.1.7 Vomiting
2.1.8 Drowsiness
2.1.9 Confusion

2.2 **A patient may present with all or some symptoms listed above and not necessarily a rash.**

2.3 If the EMD suspects the patient may have meningitis, from the symptoms described, the call should be handled as if it were meningitis.

2.4 Patients of any age can contract meningitis.

3. ProQA

3.1 There is no need to ask the Key Questions BUT be sure to enter the answers as below:

3.1.1	“Is he completely alert?”	Unknown
3.1.2	“Is he breathing normally?”	Unknown
3.1.3	“Does he have any pain?”	Other or Unknown
3.1.4	“Is he bleeding or vomiting blood?”	No or Unknown

3.2 This will ensure that 26A12 is selected and the call receives a Red response.

3.3 If using the manual card set EMDs should select the code 26A12

3.4 If the call is from an Health Care Professional (HCP) it should be triaged using Protocol 35 and selecting “Meningitis” in Key Question number one.

1. Introduction

1.1. It is recognised that patients suffering a Sickle Cell Anaemia or Thalassaemia crisis are unlikely to present with priority symptoms, but will be experiencing symptoms including extreme pain.

1.2. They should be responded to quickly.

2. ProQA

2.1 Sickle Cell and Thalassaemia are dealt with on Protocol 26 (sick person)

2.2 **The Key Questions should be answered thus:**

2.2.1	"Is s/he alert?"	Yes or Unknown
2.2.2	"Is s/he breathing normally?"	Yes or Unknown
2.2.3	"Does s/he have any pain?"	Sickle Cell or Thalassaemia.
2.2.4	"Is s/he bleeding or vomiting blood?"	No or Unknown

2.3 This will ensure a **26C3** (Sickle cell crisis / Thalassaemia) response code.

2.4 **The EMD will also need to document:**

2.4.1 The patient's name.
2.4.2 The patient's regular treatment centre.

1. Introduction

1.1. The LAS has a responsibility for the transportation of ill or injured neonates between Special Care Baby Units (SCBU) and Neonatal Intensive care units (NICU).

1.2. The Baby Emergency Transfer Service (BETS) based at the Royal London Hospital, should undertake the journeys, where the patient is being moved in an incubator.

1.3. There may be occasions where EOC are required to take the details and deal with these journeys.

2. Guidelines

2.1. The EMD must ensure that the authorising doctor has already tried to contact BETS.

2.2. The EMD must document this information in the Remarks field.

2.3. Unless the authorising doctor specifically requests a delay, all SCBU/NICU journeys requiring an incubator should be documented as an emergency event. Ensuring that ProQA is "aborted" prior to adding **ANY** information in Case Entry.

2.4. **'**SCBU' should be selected from the abort drop down list.

2.5. Call takers should inform the CTM that they are taking a SCBU journey. This will provide assistance to the call taker if required and enable sector staff to start planning the journey.

3. 3-Way Journeys

3.1. All **3-way** SCBU/NICU journeys must be recorded as SCBUEM (emergency events). Only journeys booked for the next day or beyond will be recorded as SCBUNE (non-emergency events).

3.2. Three way SCBU journeys will normally consist of:

3.2.1. Collection of the medical team and equipment, to be recorded in the Location field.
3.2.2. Collection of the baby, to be recorded in the Additional Location field.
3.2.3. Returning the baby, team and equipment to the designated hospital, to be recorded in the Transport field.

As an example:

	Example Location	Collect / Drop Off	Document Where?
1	LONDN "SCBU"	Collect Medical Team and Equipment	Loc Field
2	HOMER "NICU"	Collect Baby	Add Loc Tab
3	LONDN "SCBU"	Baby, Medical Team, Equipment	Transport Tab

4. Handling of SCBU in Dispatch

4.1. As these journeys can take considerable time to complete, whenever possible, dispatch a crew who have plenty of time to complete the journey.

5. Incubators

5.1 Incubators can be transported in all Mercedes ambulances and should be used as they:

5.1.1 Decrease manual handling issues as staff can utilise the tail lift.
5.1.2 Allow equipment to be secured safely within the vehicle.

5.2 Transfers to or from NICU or SCBU that do not require the use of an incubator should be handled as any other hospital transfer.

6. Issues

6.1 Any problems, concerns or issues must be brought to the attention of the Ambulance Operations Manager responsible for BETS, in hours by pager message and by e-mail out of hours.

1. Requests for Advice

1.1. It is recognised that members of the public will call 999/112 requesting advice.

1.2. EMDs must triage the event through MPDS and only give the instructions contained within the MPDS, including appropriate Pre-Arrival Instructions (PAI) and Post despatch Instructions (PDI).

1.3. If the caller subsequently refuses ambulance assistance, the event can be quit and recorded as 'XCALL".

1.4. Many calls for advice may result in the event being triaged as Clinical Telephone Advice (CTA) and NHS Direct (NHSD) secondary triage suitable

1.5. In these instances PDIs for secondary triage must be given as Clinical Telephone Advice (CTA) or NHSD may be able to resolve the event by giving the patient advice.

1.6. **The EMD must not give the number for NHSD in place of triaging the call.**

2. Request for General Practitioner (GP) Attendance

2.1. There may be circumstances where a caller/patient requests that a GP attends and not an ambulance.

2.2. In these circumstances EMDs should continue to record the event as normal triaging through MPDS and giving relevant PAIs/PDIs.

2.3. Call takers should also ask for, and record:

- 2.3.1. The patient's came (given name and family name)
- 2.3.2. The patient's date of birth
- 2.3.3. The GP's name
- 2.3.4. The GP's surgery address
- 2.3.5. The GP's contact number

2.4. The patients name will be recorded in the field on the EMD data tab.

2.5. The date of birth, GP details and the fact that the patient has requested a GP attendance will be recorded in the problem description field and transport tab respectively.

2.6. If the event priority is Clinical Telephone Advice (CTA) suitable then CTA or NHSD may assess the patient over the phone and decide if a GP or an appropriate care-pathway is required.

2.7. If the event is triaged as any priority, other than CTA/NHSD suitable, the following should happen

- 2.7.1. A resource must be dispatched to assess the patient's condition.
- 2.7.2. Once an on-scene assessment has taken place and the crew decides that a GP attendance is appropriate, dispatch staff can arrange it upon request by the Vehicle Crew Staff (VCS).

1. ETA Requests

1.1. When callers request an ETA for a previous event, call handlers must ask for and verify the location of the original event. Call handlers will then be able to view 'Nearby' for duplicate event(s).

1.2. EMDs must ensure they check the details of the correct event before checking the event Category – it may be awaiting a ring back from CTA or NHSD.

1.3. Viewing the Dispatch Group will show who is currently responsible for the event.

1.4. Checking the Unit Summary tab to see if a unit has been assigned, this determines whether a unit is still assigned.

2. Passing Information

2.1 The caller may then be told as appropriate, that:

2.1.1. **"Help is on the way"**
2.1.2. **"Help will be with you as soon as possible"**
2.1.3. **"Unfortunately, we don't have a resource on the way yet, but help will be with you as soon as possible."**
2.1.4. **"Your call has been referred to CTA/NHSD for further advice and they will contact you shortly."**

2.2. If a resource has been activated, it is important to point out that the information provided on the call log is only estimated by the MDT system and may change.

2.3. The caller **must not be told** how long the resource will take to reach the location.

2.4. The caller **must not be told** how far away the resource is.

3. Changing Condition

3.1 EMDs must ask if the patient's condition has changed on all ETAs.

3.2 If the patient's condition has changed in **any way** the event must be re-triaged through MPDS.

3.3 If the patient's condition has not changed, this must be recorded in the remarks field of the new EVA.

3.4 The event should always be cross referenced (XRE) with the original event.

3.5 All Events must be recorded on a new EVA (Event entry form).

3.6 ETAs must not be simply a supplement to the original event chronology.

1. Introduction

1.1. Not all 999/112 calls require an immediate ambulance response. Certain calls received are suitable for secondary telephone triage, for example by CTA or NHSD Nurse Advisors.

1.2. These instructions are to be used at all times when control is operating as normal.

2. Demand Management Plan (DMP) Stage A

2.1 Under normal operating conditions, (ie DMP Stage A), the following instructions will be given.

2.2 When an event is categorised as a C3 EM or C4, ensure that:

2.2.1 The patient's full name is documented in the EMD tab.
2.2.2 The patient's date of birth is documented in Remarks field.
2.2.3 A contact number for the patient is documented (if different from the call back number).
2.2.4 The following instructions are given:

2.2.4.1 Reassure him/her that help is being arranged.
2.2.4.2 Don't let him/her have anything to eat or drink. It may make him/her sick or cause problems for the doctor (**to be omitted for ALERT DIABETICS**).
2.2.4.3 Just let him/her rest in the most comfortable position and wait for help to arrive **(if MEDICAL related)**.
2.2.4.4 Don't move him/her unless it's absolutely necessary. Just tell him/her to be still and wait for help **(if TRAUMA related)**.
2.2.4.5 Put away any family pets.
2.2.4.6 Gather his/her/your medication, we may need to ask you about it.
2.2.4.7 From the information given, we may not dispatch an ambulance immediately.
2.2.4.8 One of our Clinical Advisors or NHS Direct may need to call you back to assess her/him/you further so the correct help/treatment can be arranged.
2.2.4.9 Please keep the phone free.
2.2.4.10 We will have someone help you as soon as possible.
2.2.4.11 **If anything changes in the meantime, call back immediately for further instructions.**

2.2.5 During inclement weather Gold Doctor may over-rule 2.2.4.4 and ask for the patient to be taken inside for shelter.

3 DMP Stage B and above

3.1 At times when the Service has activated the DMP calls other than C3 EM and C4 will become subject to secondary triage.

3.2 This does not affect the instructions given in 2.2.4 above.

3.3 Whilst at DMP B or above, action cards will be on each work station outlining to which calls these instructions should be given.

1. MPDS

1.1. The majority of 999/112 calls received in control will be triaged through the Medical Priority Dispatch System (MPDS).

1.2. MPDS allows informed decisions to be made about resource allocation.

1.3. By asking a series of questions about the presenting signs and symptoms, the EMD will select an MPDS determinant descriptor.

1.4. The Department of Health (DH) reviews and sets a priority level for all the determinant descriptors in the MPDS code set.

2. MPDS Card Sets

2.1. When using the MPDS card sets, the EMD gathers pertinent information about a patient.

2.2. The EMD selects, from a List of determinants, the most relevant determinant based on the answers to the questions.

2.2.1. In many instances more than one determinant is relevant; the EMD must decide which is the most appropriate.

2.2.2. These DH priority levels are to be found on the 'Fall Back Priority Sheet'.

2.3. The EMD must select the determinant descriptor with the highest priority level, based on the priority levels set by the DH.

3. ProQA

3.1. The EMD will gather pertinent information about a patient and enter onto the electronic system.

3.2. The answers to the questions will determine a determinant descriptor, which will be highlighted in a green band.

3.2.1. Where other determinant descriptors are also relevant they will be highlighted in a yellow band.

3.3. The EMD must select the Determinant descriptor displaying the Highest DH priority level.

Refer to Appendix 2 for more information.

1. Introduction

1.1. Many 999/112 calls result are in relations to maternity/obstetric conditions. These may result in, for example, the identification of patients with high risk complications, imminent birth, a baby born before the arrival (BBA) of VCS.

1.2. For all maternity/obstetric calls, routine or otherwise, the EMD must document:

1.2.1. The patient's name.
1.2.2. The maternity ward the patient is booked into.

2. High Risk Complications

2.1 The Medical Director recognises a number of high risk complications:

2.1.1 Premature birth (20 to 36 weeks gestation and in labour).
2.1.2 Multiple birth (over 20 weeks and in labour).
2.1.3 Bleeding Disorders.
2.1.4 Current treatment with blood thinners (anti-coagulants).
2.1.5 A patient who knows she is placenta previa and is in imminent delivery.
2.1.6 A Midwife or Health Care Professional requesting immediate assistance to a delivery or other pregnancy related problem. Note: **HCP calls should be triaged on protocol 35.**

2.2 Positive identification of **any** of these situations should result in a 24D5 determinant, ensuring a RED response.

2.3 If "birth is imminent" is selected, it will be necessary to **shift** to 24D5 ensuring a RED response.

2.4 If the caller gives any other conditions that they consider are high risk complications, the EMD should select "Unapproved other condition" from the drop down list in ProQA and document the complication in the dialogue box. This will not affect the determinant.

3. Calls from HCPs

3.1. Any calls received from Midwives or other Health Care Professionals should be triaged using Protocol 35.

3.2. Midwives and other health professionals are able to identify other pre-delivery complications, including, but not limited to:

3.2.1. Low heart rate.
3.2.2. Foetal distress.
3.2.3. Premature birth (over 20 weeks but under 36 weeks' gestation).
3.2.4. Multiple birth (over 20 weeks).
3.2.5. Eclampsia (maternal seizures)
3.2.6. Severe vaginal bleeding / post partum haemorrhage.
3.2.7. Placenta previa or placenta abruption.
3.2.8. Breech positioning or prolapsed cord.

3.3. In order to minimise this risk; **ANY** call from a HCP stating that an emergency response is required for a pre-delivery complication MUST be triaged using Protocol 35 and selecting **Obstetric Emergency** at Key Question 1.

3.4. EMDs must ensure that they free text in the Remarks field what the HCP has stated and what the problem is. This will make it clear to dispatch staff and crews what the diagnosis is.

4. Escalation

4.1 An EMD highlighting an obstetric emergency during the process of a 999/112 call must alert the CTM, who must in turn alert the relevant Area Controller and/or Allocator of the situation immediately.

1. Introduction

1.1 It is known that delayed treatment for some distal or proximal injuries can lead to the risk of neurovascular damage and/or a threat to the long term viability of the limb.

2. Identification

2.1 If the caller **does not** volunteer the information regarding the injury and/or the EMD is unclear, after asking the Key Question "what part of the body is injured?" they must ask:

"Does the limb look grossly deformed or is the bone visible (protruding through the skin) or is there an open wound over the deformed area?"

3. Overriding

3.1 When dealing with injuries where gross deformity or an open fracture is present, EMDs must select the appropriate override code in ProQA (MPDS):

3.1.1 If the determinant code is Omega select the Alpha Override.
3.1.2 If the determinant code is Alpha select the Bravo override.

3.2 The reason for selecting an "Override" must be documented in the Remarks field – for example: gross deformity / dislocation / bone visible / open fracture.

4. Proximal Areas affected:

4.1 Upper arm
4.2 Shoulder
4.3 Upper leg
4.4 Knee
4.5 Lower leg

5. Distal Areas Affected:

5.1 Elbow
5.2 Forearm
5.3 Wrist
5.4 Hand (excluding fingers)
5.5 Ankle
5.6 Foot (excluding toes)

6. Dislocations

6.1 Can also lead to neurovascular damage and therefore are included under the heading "gross deformity".

1. Introduction

1.1. This procedure sets out groups of HCPs who are able to authorise a delayed response for a patient.

2. Principles

2.1. The EMD should satisfy themselves that:

2.1.1. The HCP is exercising their own professional judgement.
2.1.2. The HCP has practitioner level responsibility for the patient.
2.1.3. The patient and the presenting medical condition fall within the HCP's area of expertise. For example:
2.1.3.1. A GP can authorise a delayed response for any type of illness/injury for a patient in their care.
2.1.3.2. A midwife can authorise a delayed response for a pregnant woman in their care.
2.1.3.3. Nurse practitioners in a Minor Injuries Unit (MIU) / Walk in Centre (WIC) requesting assistance with a patient within their treatment centre**.**

3. Additional HCPs

3.1. There are additional HCPs who can authorise delays for patients under their care. These include, but are not limited to:
3.1.1. Community/District nurses for elderly or chronically sick patients for admission to intermediate/hospice care.
3.1.2. Palliative Care (McMillan or Hospice Community Nurses).
3.1.3. Community Mental Health nurses for mental health patients.
3.1.4. LAS Clinical Telephone Advice (CTA) staff for patients whom they have assessed.
3.1.5. NHS Direct Nurse Advisors for patients whom they have assessed.
3.1.6. Certain clinically trained ambulance staff (paramedics and EMTs) for patients whom they have assessed.
3.1.7. Physiotherapists / Occupational Therapists / Chiropractors / Optometrists.
3.1.8. Emergency Bed Service (EBS) when booking a delayed response on behalf of a GP or Other HCP.
3.1.9. Dentist.

1. Introduction

1.1. It is becoming common practice to find that offices, factories, shops, civic buildings, transport hubs, etc with Public Access Defibrillators (PADs) on site.

1.2. It is also possible, but rare, for a caller / patient to have a personal defibrillator.

1.3. It is paramount that when these defibrillators are available they are deployed as soon as possible to the patient, to help increase the cardiac arrest survival rate.

2. Calls from Other Agencies

2.1. If a call is received from another agency, ie: LUL control room, the EMD taking the call must remind the caller that if a defibrillator is located on site a suitably qualified member of staff should attend the patient, with the defibrillator, whilst an LAS resource is en route.

2.2. The EMD must add **"AED dispatched"** to the remarks.

3. Calls from Members of the Public

3.1. There are occasions in MPDS where the question "Is there a defibrillator available?" is prompted.

3.2. In some post dispatch instructions, where the patient is not alert "If there is a defibrillator available, send someone to get it now in case we need it later".

3.3. This question should always be asked and this instruction should always be given, when the MPDS requires it.

3.4. If a PAD is available and someone has gone to get it, the EMD must add **"AED dispatched"** to the remarks.

1. Introduction

1.1. Increasing numbers of patients have specific treatment plans shared with the LAS.

1.2. For patient care, it is essential that these plans and records are disseminated to VCS when we receive a call to that patient.

1.3. The records may be triggered via the Locality Information System by patient address, name and/or telephone number.

2. Residential/Care/Nursing Homes

2.1. When taking a call from a Residential/Care/Nursing Home, EMDs must ensure they ask for, and document, the patient's name and confirm the name for any subsequent ETAs.

3. Mental Health Units

3.1. When a call is received from a mental health unit, contact should be made with a staff member to confirm if ambulance attendance is required.

3.2. The contact attempt and outcome, including details of staff members spoken to is to be documented on the call.

4. Safeguarding

4.1. Upon receipt of a call from (or in relation to) patients who have been or are at risk of self harm, EMDs should ensure they have a contact number for the patient (if different from the caller's (origin) number), and the name of the patient.

4.2. It should always be established if a patient is alone or not, and if so this should be documented in Remarks field, and the EMD should:

4.2.1. Establish how access will be made.

4.2.2. Stay on the line with the patient where possible.

4.3. If there is likely to be difficulty in gaining access, this should also be noted in the Remarks field.

4.4. If a possible collapse behind locked doors has been identified, this should be documented in the remarks field and sent as urgent information.

4.5. Please also refer to OP014 – Managing the Conveyance of Patients.

1. Introduction

1.1. The Helicopter Emergency Medical Service (HEMS) has a trauma doctor and paramedic on board and are targeted at severe trauma calls in order to get the skills of a doctor to the scene quickly when needed.

1.2. The London Air Ambulance is based at the Royal London Hospital in Whitechapel. When the Helicopter is "off line" the team are supported by cars.

2. Targeted Calls

2.1. To target the skills of the HEMS team appropriately, the HEMs paramedic based in EOC should be make aware of the following types of calls:

- 2.1.1. Falls higher than 2 floors.
- 2.1.2. Falls with serious injuries.
- 2.1.3. Road Traffic Collisions (RTCs) including:
  - 2.1.3.1. Trapped under vehicle **–** including "One Under" a train.
  - 2.1.3.2. Ejected
  - 2.1.3.3. Associated Fatalities
  - 2.1.3.4. Any other RTC with serious injuries.
- 2.1.4. Assaults including:
  - 2.1.4.1. Stabbings
  - 2.1.4.2. Shootings
- 2.1.5. Drowning
- 2.1.6. Head injuries
- 2.1.7. Electrocution
- 2.1.8. Industrial accidents
- 2.1.9. Explosions
- 2.1.10. Traumatic amputations (above wrist/ankle)
- 2.1.11. Ambulance crew request
- 2.1.12. Service request from:
  - 2.1.12.1. Police
  - 2.1.12.2. London Fire Brigade (LFB).
  - 2.1.12.3. Neighbouring ambulance services

1. Introduction

1.1. There are instances where an anxious relative in the UK will call for an ambulance for a relative who is outside the UK. This procedure explains how these calls should be routed to ensure that they are passed on to the relevant emergency service.

2. Call Taking

2.1. The caller should be asked if it is possible for them to direct the patient – or someone with the patient to call for help in their own country.

2.2. If this is not possible, the CTM or CHS should be alerted to the fact that you are taking a call from outside of the UK.

2.3. Complete the call as usual, paying particular attention to the address, which may be in a different format – for example many countries put the house number after the street name.

2.4. For the caller and patient number ensure that you also get the country dialling code – where possible.

2.5. Document in the Remarks field the language normally spoken by the caller and the patient.

3. CTM/CHS

3.1. The CTM and/or CHS should assist the call taker as needed to confirm the location of the patient and alert the OCM of the call, and where the patient is located.

4. OCM

4.1. Identify the country the patient is in, and identify the telephone number for the appropriate control centre from the international directory folder held on the OCM desk.

4.2. Note the telephone number, including the country dialling code.

4.3. Where there is no number listed, Clinical Support desk (CSD) can assist in locating a number.

4.4. Identify an EMD to pass the call.

5. EMD Passing the Call

5.1. Contact the relevant control, bearing in mind the following:

5.1.1. The call centre may not be a specific ambulance control – the call may be taken by police or fire call handlers.

5.1.2. Within the EU the call centre is required to be able to take the call in English.

5.1.3. If the call centre cannot take the call in English, or if it appears that there may be a delay finding a translator, consider the use of the Language Translation Service.

5.1.4. Identify yourself as passing a request for emergency medical help from the London Ambulance Control for a patient in their country.

5.1.5. Pass all of the details that we have been able to get.

5.1.6. Take a reference number for the call, or the initials of the person who took the details.

5.1.7. Record all the details, including the phone number used to contact the relevant control as supplement information in the event chronology.

6. Complications

6.1. If unable to identify an emergency call centre in the same country as the patient any call centre within the country should be able to help – it need not be the call centre that covers the specific area.

6.2. If either the patient or the caller is a UK citizen then the Foreign and Commonwealth Office will be able to assist.

6.3. The national embassy of the country concerned in the UK may be able to assist.

6.4. The UK embassy in the specified country may be able to assist.

6.5. In extreme circumstances many large multinational companies that have a presence in that country may be willing to help – if it has proved impossible to arrange help by other means.

1.0 Introduction

1.1 This procedure outlines the use of recorded messages to relay post 999 call actions (case exit) to patients or callers.

1.2 A patient or caller requesting help via 999 will be taken through the call handling process by the EMD who will progress through Case Entry, Key Questions and any appropriate and necessary protocol or condition specific Post Dispatch Instructions. At this point, the EMD will identify if the patient is suitable to be given the recorded case exit instructions.

1.3 EMD's have the responsibility to identify if a caller requires additional support – for example identifying if a caller would benefit from the use of language line, or if they need to stay on the line. The use of these recorded messages is no different, and it is the EMD's responsibility to identify whether the use would be appropriate. If the decision is made to verbally deliver the exit protocol information (for example through an interpreter), the EMD will need to record the reason on the call receipt. e.g. "***Exit message not used – Language line".***

1.4 A patient or caller will be transferred by the EMD to the appropriate recorded message. What they will hear will be appropriate to the call's determinant – either R2, C1, C2 calls or C3, C4 calls (secondary triage). A patient or caller will be able to repeat the message if it is not understood (instructions are given to the caller as part of the recorded message).

1.5 DMP - Recorded Messages will not be used if DMP has been initiated – EMD's will utilise the relevant DMP action card as issued by the Call handling manager.

1.6 The recorded messages are not to be used when speaking with HCP calls and any 4th party agencies (e.g. Police, Fire, London Transport, etc).

Refer to Appendix 3 for more information

IMPLEMENTATION PLAN				
Intended Audience	Control Services Staff			
Dissemination	Available to all Staff on the Pulse			
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document.			
Training	EOC – Watch training leads to ensure dissemination and familiarity of staff with 1-2-1 and scenario based sessions.			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**
Operational Aspects	Monitoring compliance on a day to day basis will be undertaken by all managers by observing staff during duty hours. 3 yearly review to be conducted	EOC OCMs will monitor watch and produce a report for the Performance Improvement Manager EOC, for reporting to the Control Services Change Board (CSCB)	Control Services Change Board (CSCB)	Bulletins and amendments to procedure as deemed necessary A revised Procedure to be published as above
Technical Aspects	Monitoring compliance on a day to day basis will be undertaken by all managers by observing systems during duty hours.	EOC OCMs will monitor watch and produce a report for the Performance Improvement Manager EOC, for reporting to the Control Services Change Board (CSCB)	Control Services Change Board (CSCB)	Bulletins and amendments to procedure as deemed necessary A revised Procedure to be published

	3 yearly review to be conducted			as above

Appendix 1 - Glossary of Terms

112	The Emergency phone number recognised in the EU
999	The Emergency phone number in the UK
AED	Automated External Defibrillator
AEU	Ambulance Emergency Unit
ALS	Advanced Life Support
AOM	Ambulance Operations Manager
BBA	(Baby) Born Before Arrival
BETS	Baby Emergency Transfer Service
BLS	Basic Life Support
CAD	Computer Aided Dispatch
Card Set	Card index version of MPDS
CBRN	Chemical, Biological, Radiological, Nuclear
Chronology	Event Log
CHS	Call Handling Supervisor
CIO	Community Involvement Officer
CLI	Caller Line Identity
CP	Communication Provider
CRU	Cycle Response Unit
CSD	Clinical Support Desk
CSOP	Control Service Operational Procedure / Policy
CSU	Central Support Unit
CTA	Clinical Telephone Advisor / Advice
CTM	Call Taking Manager
Distal	Situated away from the point of origin or attachment, as of a limb or bone
DMP	Demand Management Plan
DoH / DH	Department of Health
DSO	Duty Station Officer
EA	Emergency Authority
EBS	Emergency Bed Service
EMD	Emergency Medical Dispatcher
EOC	Emergency Operations Centre
ETA	Estimated Time of Arrival
EU	European Union
EVA	Event Form
FRU	Fast Response Unit
GP	General Practitioner
GPS	Global Positioning Satellite
GS	Gazetteer search

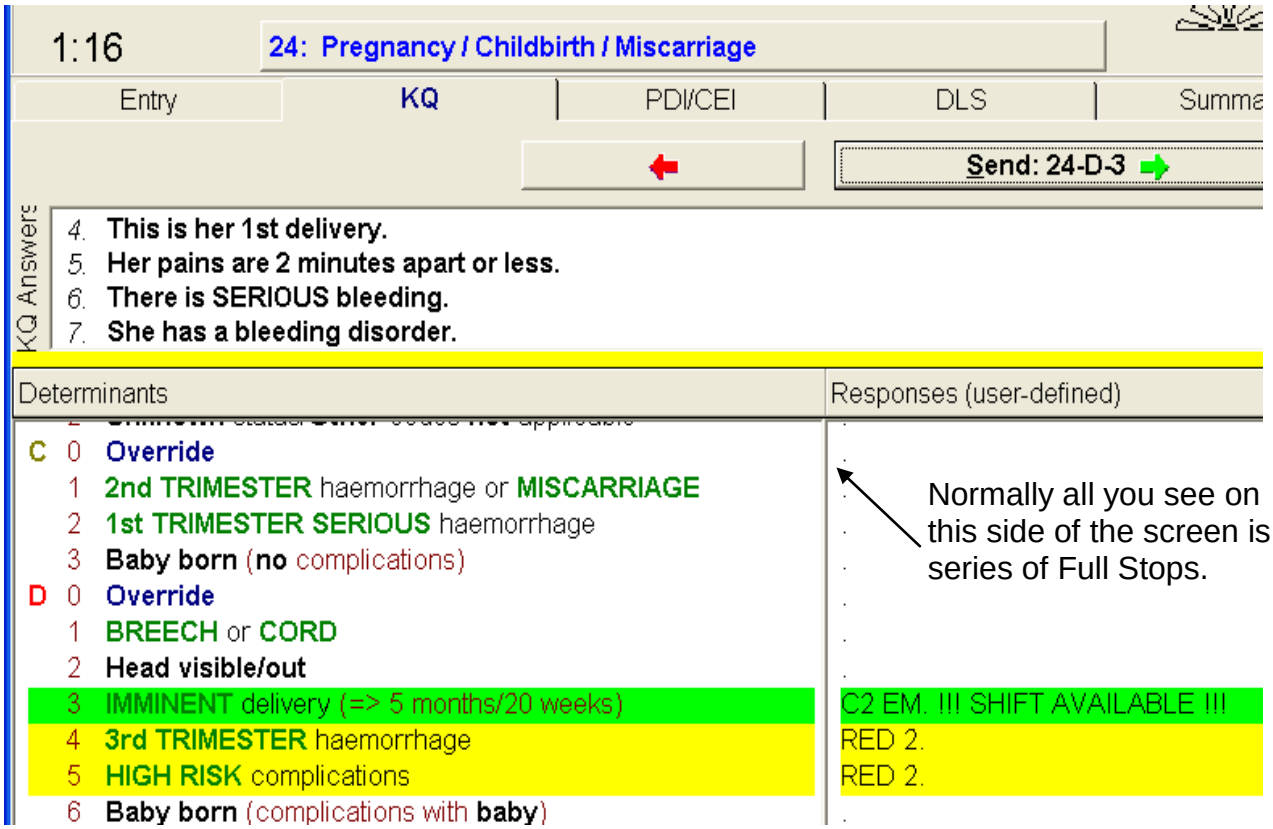
HART	Hazardous Area Response Team
HAZMAT	Hazardous Materials
HCP	Health Care Professional
HEMS	Helicopter Emergency Medical Service
IDP	Individual Dispatch Protocol
IED	Improvised explosive devices
IRT	Incident Response Team
LAS	London Ambulance Service NHS Trust
LFB	London Fire Brigade
LUL	London Underground Limited
MDT	Mobile Data Terminal
Minicom Text Phone	A communication device for people who are deaf / hard of hearing or have speech problems
MIP	Major Incident Plan
MIU	Minor Injuries Unit
MPDS	Medical Priority Dispatch System
MPS	Metropolitan Police Service
NHS	National Health Service
MRU	Motorcycle Response Unit
NHS SMS	NHS Security Management Service
NHS SMS LPU	NHS SMS Legal Protection Unit
NHSD	National Health Service Direct
NICU	Neonatal Intensive Care Unit.
NSY	New Scotland Yard
OCM	Operations Centre Manager
One Under	A person trapped under a train.
OP	Operational Procedure / Policy
PAI	Pre-Arrival Instructions
PC	Personal Computer
PCAT	Patient Centred Action Team
PCT	Primary Care Trusts
PDA	Personal Digital Assistant
PDI	Post Dispatch Instructions
PECS	Public Emergency Call Service
PRF	Patient Report Form
ProQA	A computer software programme than runs MPDS
Proximal	Situated toward the point of attachment, as of a limb or bone
QAD	Quality Assurance Department
RC	Resource Centre
RIB	Routine Information Bulletin
RIPA	Regulation of Investigatory Powers Act
RTC	Road Traffic Collision
RVP	Rendezvous Point
SCBU	Special Care Baby Unit
Silent call	No Voice contact
SMG	Senior Management Group
SMS	Short Message Service

SPOC	Single Point Of Contact
STEP 1-2-3	Method of approach at scene of multi-patient incidents
TP	Training Protocol
TSO	Tactical Support Officer
UC	Urgent Care
UCS	Urgent Care Services
USAR	Urban Search and Rescue
VAS	Voluntary Ambulance Service
VCS	Vehicle Crew Staff
VDI	Vehicle Daily Inspection
VoIP	Voice over Internet Policy / Provider
VOR	Vehicle Off the Road
VRC	Vehicle Resource Centre
WIC	Walk in Centre

Appendix 2

SHIFTING in ProQA.

Whether using ProQA or the Card sets please ensure that you always select the most appropriate Determinant.



In this example the patient is a 24 YOF. She is in Labour with her First Baby, she has serious bleeding and a Bleeding disorder

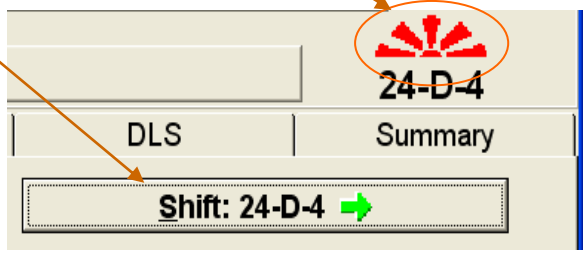
Therefore more than one determinant is relevant, this patient is in Imminent delivery (D3), she is haemorrhaging (D4) and she has a blood disorder (D5).
ProQA highlights D3 in green simply because it is the highest in the Numbering sequence (7 low —1 high) it also highlights D4 and D5 in yellow as they are also available to select.

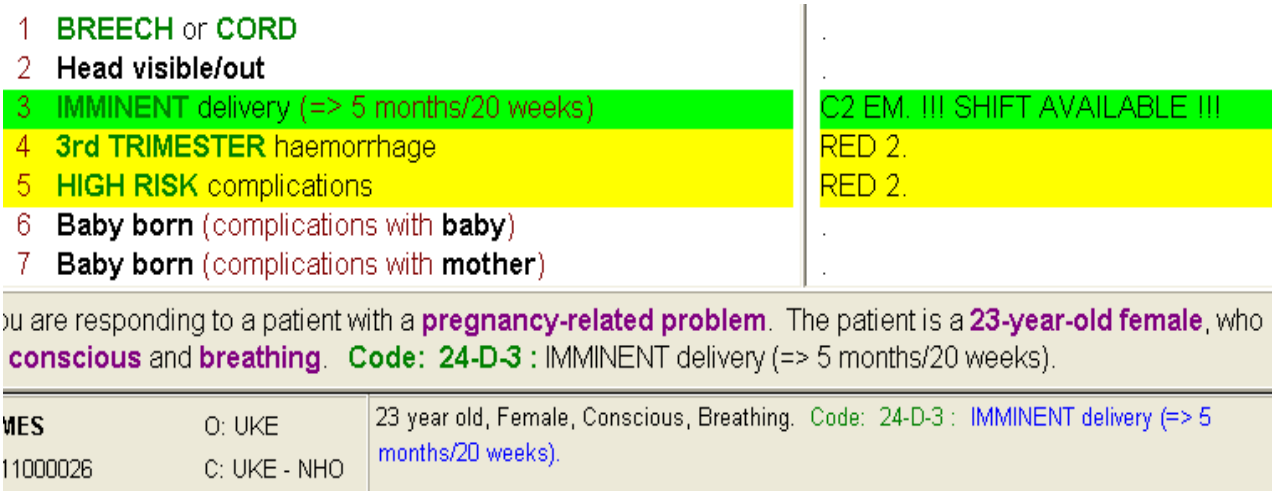
Note: in these instances the Response code has been input to assist in selecting the Highest LAS response for the call.
Sometimes, due to the size of the screen, only the determinant highlighted in Green will be visible, however the “SHIFT AVAILABLE” should be a prompt to scroll down and check.

Having selected D4, by moving the cursor, the

becomes **Shift: 24-D-4**

The Quadrant Timer





As the determinant is selected the Quadrant timer will turn Yellow. The quadrant timer will stay yellow until the call is completed. This is simply as a reminder that there is a Shift available.

It is worth remembering that if the Quadrant timer is Yellow click on it just to ensure that the highest LAS code has been selected.

Appendix 3 - Recorded 999 Message Transcripts (for reference only)

Message/Button - '*EXIT - R2, C1, C2'*
(R2, C1, C2 Determinants):

1. Emergency help is being arranged.
2. In the meantime, the patient should not have anything to eat or drink, except sips of water until told otherwise - it might make them sick or cause problems for the Doctor. If the patient is a diabetic and is fully awake, remind them to do what their Doctor has instructed for these situations.
3. If the patient has a medical condition, they should rest in the most comfortable position and wait for help to arrive.
4. If the patient has an injury, they should not move unless it's absolutely necessary. Just be still and wait for help to arrive.
5. Watch the patient very closely.
6. If the patient becomes less awake and vomits, quickly turn them onto their side.
7. If possible, please put away any family pets, gather the patient's medications, unlock the door and have someone meet the emergency crew.
8. During the hours of darkness, turn on the outside lights.
9. If the patients condition changes or gets worse in any way, or they have a fit, call us back immediately for further instructions on 999.
10. Emergency help is being arranged.
11. You may put the phone down now

Message/Button – '*EXIT – C3, C4'*
(C3, C4 Determinants):

1. From the information given, we may not dispatch an ambulance immediately. One of our Clinical Advisors or NHS Direct may need to call you back to assess the patient further so the correct help/treatment can be arranged. Please stay by the phone. We will have someone help you as soon as possible.
2. In the meantime, the patient should not have anything to eat or drink, except sips of water until told otherwise - it might make them sick or cause problems for the Doctor. If the patient is a diabetic and is fully awake, remind them to do what their Doctor has instructed for these situations.
3. If the patient has a medical condition, just let them rest in the most comfortable position and wait for help.
4. If they have an injury, do not move them unless it's absolutely necessary. Just tell them to be still and wait for help.
5. If possible, please put away any family pets and gather the patient's medications.
6. If the patients condition changes or gets worse in any way, or they have a fit, call us back immediately for further instructions on 999.
7. Help is being arranged.
8. You may put the phone down now.