London Ambulance Service NHS Trust

Control Services - Dispatch Procedures

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Sponsor Department: Control Services

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1. Introduction

The London Ambulance Service (LAS) attends a diverse range of patients, often in unique and demanding circumstances. Approximately 3500 emergency and Non-emergency calls are handled in the Operations Centre daily.

2. Scope

The procedures contained in this document specify actions and information additional to those within OP23 (Dispatch of Resources by Emergency Operations Centre) required for Emergency Medical Dispatchers (EMD's) to ensure the most appropriate dispatch of resources to emergency and non-emergency calls.

3. Objective

To ensure that all emergency and non-emergency calls have the most appropriately dispatched resource within their specified time frame.

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 (EMD's)** 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. Procedures

The following sections provide specific procedures needed for dispatch.

Procedure A	No Trace / No Reply Incidents	Version 1.0

1. Introduction

1.1. There are occasions when Vehicle Crew Staff (VCS) arrive at a location given by control and there is ‘No Trace’ of the patient or ‘No Reply’ at the incident location.

1.2. Control staff have the responsibility to ensure that any events reported by the crew as No Trace or No Reply have the location details checked and verified before forcible entry is made or the crew is withdrawn.

2. Upon Report of No Trace / No Reply

2.1. EMD should call back the origin number, and/or any other number provided, to confirm the location and other details.

2.2. If unable to make contact with the origin caller, confirm the location by checking the audio recording of the original call. *This should be done by an OCM or Area Controller.*

2.3. Ensure that the crew has tried other means of gaining access to the location.

3. Possible Actions

3.1. Request VCS to make a thorough search of the immediate area or location where applicable.

3.2. If appropriate, check with local hospitals including minor injuries/walk-in centres, to see if the patient has made their own way.

3.3. If there is an indication that someone may have left scene, possibly ill or injured the crew should carry out an area search, and control should alert other agencies as appropriate (e.g. Police).

3.4. VCS should only be withdrawn from scene once it is clear that the patient is not inside the address and an area search has been completed and the patient has not been located.

3.5. These actions apply to calls that are both inside and outside locations.

3.6. It is imperative that all actions are fully documented in the Event chronology and on the VCS Patient Report Form (PRF). If control is operating in paper operations mode the handwritten ticket must be documented accordingly.

4. Collapsed Behind Closed Doors

4.1. The call should only be treated as a possible collapsed behind doors after the location has been confirmed and access cannot be gained (see Appendix 2 for more details).

4.2. The police should be requested to assist in gaining entry.

1. Introduction

1.1. Some 999/112 calls may require consideration of a specialist attendance.

1.2. The Hazardous Response Team (HART) consists of the Incident Response Team (IRT) and Urban Search and Rescue (USAR).

2. Responding

2.1. The HART IRT should be considered for dispatch in the following circumstances:

2.1.1. Serious/Major Incidents
2.1.2. Fire calls – persons reported / industrial fires
2.1.3. Explosions or Improvised explosive devices (IEDs)
2.1.4. Suspect packages
2.1.5. Calls involving illicit drug laboratories
2.1.6. Carbon monoxide / smoke inhalation incidents
2.1.7. Underground Incidents *excluding calls to single patient medical emergencies.*
2.1.8. Underground trains stuck in tunnels
2.1.9. Train incidents above ground *excluding calls to single patient medical emergencies.*
2.1.10. Road Traffic collision (RTC) with multiple patients or vehicles
2.1.11. RTC involving vehicle carrying a hazardous load
2.1.12. STEP 123 incidents
2.1.13. Chemical Biological Radioactive Nuclear (CBRN) / Hazardous Materials (HAZMAT) – release of substances
2.1.14. Radiation incidents / Electronic Personal Dosimeters (EPD) activations
2.1.15. Airport / Aircraft incidents
2.1.16. Duty Station Officers (DSO) / Crew request
2.1.17. Fire or Police service request
2.1.18. EOC should consider HART when deploying multiple resources

2.2. HART USAR should be considered for dispatch in the following circumstances:

2.2.1. Collapsed/Unsafe structures (incl. scaffolding)
2.2.2. Casualty at height (cranes/scaffolding/buildings)
2.2.3. Casualty in a confined space
2.2.4. Where Fire Service have deployed their USAR team

2.3. HART resources should also be considered to **assist with difficult removals or as additional support to a patient in cardiac arrest**.

3. Dispatch

3.1. HART resources are <u>not</u> to deploy unless directed by EOC.

3.2. Dispatch of HART is conducted by LAS EOC alone. Partner agencies requesting the attendance of HART are to request HART though established EOC contact mechanisms.

3.3. HART staff are not trained to offer advice to ambulance officers in command roles.

3.4. EOC will dispatch an operational officer to all incidents attended by HART, who will act as a Forward Incident Officer.

3.5. The deployment of HART should not negate the need to page, if appropriate (via the OCM desk), the on duty/call Tactical Support Officer.

4. Operational Areas

4.1. The WEST HART cover North West, West and South West.

4.2. The EAST HART cover: North East, East Central, Central and South East.

4.3. Although each team has an operational area, the nearest team to an incident will be dispatched even when the team who cover that area are available. If one team is unavailable or on another call, the alternative team should be utilised.

1. Introduction

1.1. The Duty Station Officer (DSO) is an operational manager with responsibility for real time station and operations management at a complex level. This section provides details relating to matters that should be brought to the attention of the DSO.

2. Operational Incidents

2.1. In the case of operational incidents it should always be the *nearest* available DSO that is notified.

2.2. A preliminary discussion is to take place between the Area Controller and DSO prior to dispatch (telephone handshake). If the Area Controller is unavailable this may be delegated to the Allocator working with that dispatch group.

2.3. The DSO and Area Controller (or delegated Allocator) should enter into a preliminary discussion to agree the appropriate response to any given incident.

2.4. Where the decision is made for DSO attendance, the event details are to be sent to the DSO in the usual manner.

2.5. The Area Controller should draw upon the operational experience of the DSO when deliberating the best course of action.

2.6. The corresponding event chronology is to be updated with the agreed course of action.

2.7. The Area Controller retains the primacy regarding immediate DSO activation.

2.8. The matter may be escalated through the arbitration process as outlined in this document once the incident has concluded.

2.9. A list of incidents that a DSO is to be informed of is contained in **Appendix 3.**

3. Welfare Incidents

3.1. Welfare incidents are to be brought to the attention of the relevant complex DSO.

3.2. Where the complex DSO is not available, the neighbouring complex DSO is to be utilised.

3.3. A DSO is to be alerted to welfare matters via telephone from the dispatch group desk.

3.4. Once the DSO has been alerted, ownership is transferred to the informed DSO.

3.5. A list of incidents that a DSO is to be informed of is contained in **Appendix 3**.

4. Performance Incidents

4.1. Performance incidents are to be brought to the attention of the complex DSO. Where the complex DSO is not available, the neighbouring complex DSO or nearest '99 DSO is to be utilised.

4.2. DSOs will be made aware of vehicle off the road matters via text or phone by Central Support Unit (CSU) and/or Vehicle Resource Centre (VRC).

4.3. A list of incidents that a DSO is to be informed of is contained in the **Appendix 3**.

5. Arbitration Escalation

5.1. The aim of any arbitration is to ensure learning opportunities are identified and that matters are resolved expediently with those directly involved.

5.2. Arbitration is to take place after the incident has been managed.

5.3. Where a DSO discovers this protocol has not been followed or would like to discuss the dynamic decisions made, the first point of escalation is with the Area Controller on duty.

5.4. Should this remain outstanding or unresolved for either party, the matter is to be referred to the OCM on duty and then with the AOM on duty.

5.5. Where matters are discovered historically, details are to be forwarded to the Control Services Business Development Manager who will register the matter and refer it to the watch AOM who will undertake enquiries or delegate this to a member of the watch management team.

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 transported by their own marked cars.

1.3. The HEMS team can either be dispatched immediately by the paramedic in EOC or they will call back for further questioning before making the decision to deploy.

2. Immediate Dispatch

2.1. The following calls should be immediately dispatched to:

- 2.1.1. Falls higher than 2 floors.
- 2.1.2. Road Traffic Collisions (RTCs) including:
  - 2.1.2.1. Trapped under vehicle **-** including “One Under” a train.
  - 2.1.2.2. Ejected
  - 2.1.2.3. Associated Fatalities.
- 2.1.3. Traumatic amputations (above wrist/ankle)
- 2.1.4. Ambulance crew request
- 2.1.5. Service request from:
  - 2.1.5.1. Police
  - 2.1.5.2. Fire
  - 2.1.5.3. Neighbouring ambulance services

3. Further Interrogation

3.1. The following calls warrant further interrogation before dispatching:

- 3.1.1. Any other Fall with serious injuries
- 3.1.2. Any other RTC with serious injuries
- 3.1.3. Assaults, including
  - 3.1.3.1. Stabbing
  - 3.1.3.2. Shootings
- 3.1.4. Drowning
- 3.1.5. Head Injuries
- 3.1.6. Electrocution
- 3.1.7. Industrial Accidents
- 3.1.8. Explosions

4. Communication

4.1. The HEMS paramedic in EOC should be informed of any of these types of calls by:

- 4.1.1. Call Taking staff.
- 4.1.2. Dispatch staff.
- 4.1.3. VCS via a requested Report on Arrival (ROA)

1. **Introduction**

1.1. There are occasions when an EMD or an Allocator needs to cancel a resource that has been assigned to a call by either automatic or manual dispatch.

1.2. For the purpose of this document, the term Allocator refers to the role and not the rank of the individual performing the role and includes all staff involved in the dispatch of resources.

2. Cancelled for Quicker Responding Unit (Pre-empt)

2.1. When cancelling a resource for a quicker responding unit, Control staff must ensure that the quicker responding unit is en route <u>before</u> sending a cancellation to the MDT of the resource being cancelled.

3. Cancelling for a Higher Priority Event(Pre-empt)

3.1. A resource should only be cancelled for a higher priority event when the event has received a higher priority value than the incident the resource is responding to.

4. Cancelled for Clinical Telephone Advice / Appropriate Response (Pre-empt)

4.1. A resource should only be cancelled for Clinical Telephone Advice/Appropriate Response once the call has received an appropriate priority which is suitable for CTA, NHS Direct or an A&E Support resource and the Call Taker has completed the call.

4.2. Once the resource has booked available on Road (AOR) the call should be manually transferred to CTA or other relevant sector (dispatch group) using the relevant CAD functionality.

5. Cancelled by Unit On scene and Dealing(Pre-empt)

5.1. A resource may be cancelled at the request of a unit on scene where their attendance is no longer required.

6. Cancelled as Resource Unavailable (Pre-empt)

6.1. A resource may be cancelled as they are in an ‘unavailable’ status (see OP44) such as ‘broken down’ or ‘infectious’, or in the uninterruptible portion of their rest break.

7. Cancelled – No Longer Required (Pre-empt)

7.1. A resource should be cancelled if they are no longer required when a cancellation is received from:

- 7.1.1. The original caller.
- 7.1.2. The MPS cad link.

8. Event Cancel – No Longer Required (EX)

8.1. Due to a “ring back” where the patient has recovered and a resource is no longer required.

8.2. A cancellation has been received advising that ambulance resources are not required.

8.3. An LAS clinician has made contact with the patient and offered an appropriate care pathway.

8.4. A Control Manager has made a decision that an LAS response is not appropriate or out of protocol, for example: during the Demand Management Plan.

8.5. A call has been passed to an outer county service and it has been confirmed that an LAS response is not required.

9. Chronology – Showing the reason for cancellation

9.1. In all instances it is **essential** that the EMD or Allocator ensures that the appropriate reason for the cancellation and any further information is fully recorded in the Event Chronology.

1. Introduction

1.1 The response profiling system determines which resources are needed to attend each event, and are based on unit type and skill levels. The response profiles have been assessed by MPDS determinant and agreed by the Deputy Medical Director and Deputy Director of Operations.

1.2 All staff in the dispatch area should always ensure that every attempt is made to meet the response profile assigned to each individual call.

1.3 The details of the response profile can be seen on the unit suggestion display of each event either in Suggestion Info and / or Response Plan tabs.

2. Automatic Dispatch

2.1 If the event has automatic dispatch enabled, the automatic processes should always attempt to meet the response profile until any resource starts conveying to hospital. During this time the dispatcher can request a unit suggestion which will also display the quickest responders based on the response profile, which can be allocated manually at any time.

2.2 Automatic dispatch will re-evaluate the response profile each time the event type changes, and will look to send the quickest resource based on the response profile. This may result in multiple resources being sent during different stages of the event, when the type is changed i.e Chief Complaint and Determinant. Should this happen the dispatcher will be sent an urgent message, informing them the response profile has been exceeded by said resources and advising that they should be cancelled.

2.3 Should the response profile not be met by automatic dispatch, this will be shown on the unit suggestion display, as the deficiency tab will be highlighted.

2.4 Automatic dispatch will be limited to a maximum drive time limit . It will not consider units assigned to other events or activate units with a greater than specified drive time limit . Quicker responding units meeting the response profile will be displayed via unit suggestion panel.

3. Manual Dispatch

3.1 There are a number of events where automatic dispatch is suspended or disabled for a number of reasons. In these occasions dispatchers will need to follow the manual process as identified in 2.1.

4. Ongoing Review

4.1 The response profiles based on determinants are subject to ongoing review by the Deputy Medical Director and the Deputy Director of Operations North and South

1. Introduction

1.1 There are occasions that a number of incoming events for the same patient and / or location are received and this guidance is designed to ensure that these are managed consistently and correctly, based on best practice and also in accordance to KA34.

1.2 Should an event be held in either Clinical Telephone advice (CTA), Clinical Hub or EOC and a lower priority duplicate event be received; then the highest priority event should be retained and the lower priority event duplicated to the primary event.

1.3 Ambulance resources en route to an event should not be cancelled to be sent to a higher priority duplicate event. The DUP function within CommandPoint™ ensures that any different critical information is alerted to the responding resource. This will be sent via MDT message, however should be followed up by the dispatcher with a verbal message via radio communication.

1.4 Any relevant information regarding the duplication of event(s), and / or any decisions made in determining duplicate events should be fully recorded on the event chronology by the dispatcher.

2 Multiple Events for same event / patient. (Often events in public places)

2.1 Once the first event has been activated upon, any subsequent events will have automatic dispatch suspended due to the nearby function in CommandPoint™. These duplicate events should be aligned with the original call using the DUP function in CommandPoint™.

2.2 The duplicate function also ensures that if any of the duplicate events have a higher call prioritisation that this is displayed on the original call.

3 Event in CTA/Clinical Hub, updated event received with increased priority

3.1 The original event in CTA/Clinical Hub would have automatic dispatch disabled based on event type and dispatch group. Once an update has been received requiring attention this updated event should be dispatched upon using manual recommendations. Automatic dispatch would be suspended due to the nearby function being enabled. Alternatively, auto dispatch could be 'forced' into enabled via the EDIT function on this updated event to allow the automatic processes to fully function and dispatch on the updated event.

3.2 It is the responsibility of the dispatcher to contact CTA/Clinical Hub of the updated event. The original event should then be aligned to the updated event via the DUP function.

4 Event being held in EOC, an updated event received with increased priority.

4.1 The updated event should be allocated on manually as per process in 3.1.

4.2 The original event should then be aligned to the updated event via the DUP function.

1. Introduction

1.1 To ensure that identified Major Incident's can be appropriately dispatched upon either via Automatic or Manual Dispatch; specific Major Incident Event Types should be selected either in call handling or dispatch areas.

2. MAJORA Event Type:

2.1 This event type will be enabled for automatic dispatch to ensure that appropriate levels of resources are activated to support the initial management of the event.

2.2 Automatic Dispatch will move to a suspended status once the response profile has been reached or once the first resource moves to a transporting status.

2.3 The default event priority for MAJORA event type is Red 1.

2.4 Due to the number of ambulance resources likely to be sent should this event type be selected, caution needs to be exercised before utilising this event type. If at any stage there is uncertainty staff should liaise with a supervisor or manager for further guidance.

3. MAJORB Event Type:

3.1 This event type is to be used after the initial cohort of ambulance resources have been activated and / or arrived on scene, to allow further manual management of the incident to occur. This will allow for further units to be activated based on the response profile.

3.2 Automatic dispatch will be disabled based on event type.

3.3 The default event priority for MAJORB event type is Red1.

4. RVPACC Event Type:

4.1 This event type is used to identify an aircraft accident on / off airport or an imminent accident. This should be selected by either call handling or dispatch.

4.2 The response profile will be identical to that of MAJORA; however automatic dispatch will be disabled due the potential for crew safety implications with this type of call.

4.3 Once more information is ascertained; the dispatcher should use the EDIT function and change the event type to MAJORA to ensure automatic processes are enabled.

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 Vehicle Crew Staff (VCS).

2. Management of Obstetric Emergencies

2.1 Call takers receiving an obstetric emergency during the process of a 999/112 will have alerted the Call Taking Manager (CTM). In turn the CTM must alert the relevant Area Controller and/or Allocator of the event immediately.

2.1. Dispatch staff must make every effort to dispatch a crew for **EACH** patient, i.e. if twins are expected then three crews will be required, one for each baby and one for the mother.

2.2. At least one of the crew must be a Paramedic. These crews should be released at the earliest opportunity if not required.

2.3. The patient must be transported to the nearest obstetric unit with all possible speed preceded by a hospital pre-alert (blue call) if any complications arise relating to the labour and/or the mother's condition.

2.4. In these circumstances a midwife should not be sent to scene as this may delay the crew transporting the mother.

2.5. The exception being if the baby is in the process of being delivered and the mother cannot be moved.

3. Management of Medical or Traumatic Emergencies

3.1. A medical or traumatic emergency may puts the life of the mother, and baby, in imminent danger (e.g. trauma/epilepsy related seizure).

3.2. The appropriate treatment for the presenting condition must be initiated and the mother should be transported to the NEAREST Emergency Department, preceded by a pre-alert.

4. Staff Support

4.1. The Area Controller and/or Allocator may, where appropriate, ensure that a Team Leader or officer is alerted to provide VCS support.

4.2. In instances where further advice/guidance is required, this is available from Clinical Support desk (CSD), an obstetric unit or the hospital the patient is booked under for the pregnancy.

5. Normal Labour

5.1 If the patient is experiencing a normal labour/delivery, it is likely the crew will request a midwife to scene.

5.2 Dispatch staff should arrange this as a priority and document all actions on the Event Chronology.

1.0 Introduction

1.1 Due to the increased potential of pre hospital intervention and benefits to clinical outcomes that can be provided to the patient for certain types of emergency requests, dispatchers should always attempt to activate a paramedic trained personnel to certain types of events.

1.2 As per section F, the response profiles have been set to establish what should be responding to each event. Dispatcher's should always strive to meet these response profiles to ensure the best possible patient care can be provided.

1.3 The Medical Directorate have stipulated the following event types should always be responded to by a paramedic skill level or above. Should this not be completed, the dispatcher must fully record the reason on the event chronology.

- Cardiac Arrest
- Continuous Fitting (as at end of 999 call)
- BBA and / or obstetric emergency (see Procedure I)

1.4 Every effort should also be made by the dispatcher to ensure that a minimum of three LAS personnel should attend a cardiac arrest, one of which having a minimum of paramedic training and registration. This will ensure that the most effective pre hospital treatment can be provided.

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. Actions for Dispatch

2.1 Any request for assistance should always be followed with an appropriate response. Dispatch staff should not question the integrity of the caller, or of any information passed in relation to a potential or actual patient.

2.2 Where CCTV exists an OCM must check it, in an effort to trace any potential patient.

2.3 Further ring backs if made should be fully documented on the event chronology, and at any time further details be obtained, then a fresh event should be and the abandoned call event be closed via the DUP function.

2.4 Should the request be made to a public phone kiosk, the attending crew should be asked to confirm the telephone number on display at the telephone kiosk to check the correct phone location has been attended.

1. Introduction

1.1 The key purpose of the Clinical Co-Ordination Desk (CCD) is to receive all priority – known as 'blue' calls from operational resources and pass the details to the appropriate hospital unit.

1.2 The desk is staffed by a number of EMD's working in conjunction with the HEMS paramedic, and in consultation with operational colleague's co-ordinate admissions to Major Treatment Centre's (MTC), Hyper Acute Stroke Units (HASU) and Cardiac Catheterisation Unit's (CCU) located across London.

2 Dispatch Activity

2.1 The EMD on the CCD will receive all 'blue' calls from operational resources utilising radio talk-group PD09.

2.2 In the event that an operational resource is getting nil reply from PD09, they may call EOC via a normal dispatch talk-group. In this event, the EMD must take all the details and pass the details to the receiving hospital without delay. Should this blue call be going to a MTC, HASU or CCU then the CCD EMD should be updated to ensure that hospital capacity can be closely monitored.

2.3 All information regarding the details MUST be fully recorded on the event chronology, including full details of the patient diagnosis, crew conveying, the hospital patient being conveyed to, the time details received and the time passed.

2.4 The EMD may be asked to monitor incoming events to assist the HEMS paramedic and also to assist the staff on the Clinical Hub. Whilst EMD's should be encouraged to follow the Trauma Triage Tool in providing assistance to operational resources, they should not give any clinical guidance under any circumstance. Any clinical questions should be directed to the appropriate clinician.

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. 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

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 Identification
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 Practioner
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

OP14 - Managing the Conveyance of Patients Policy and Procedure

Point 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.

Appendix 3

Duty Station Officer Tasking Guidance for EOC Staff

<table>
<tr><th colspan="2">Incidents likely to require an immediate DSO attendance</th></tr>
<tr><td>Major Incidents or Serious Incidents</td><td>Railway Incidents (any type)</td></tr>
<tr><td>Multiple ambulance/resource attendance at one call</td><td>CBRN / HAZMAT</td></tr>
<tr><td>Ambulance Collisions – response only if injuries involved</td><td>Civil Disorder / Demonstrations</td></tr>
<tr><td>Serious Trauma Calls/HEMS Activations</td><td>Aircraft Incidents</td></tr>
<tr><td>Helicopter Landing Sites, e.g. RAF or outer county transfer</td><td>Paediatric cardiac arrest</td></tr>
<tr><td colspan="2">Armed Incidents Firearms / Knives or where weapons are suspected</td></tr>
<tr><th colspan="2">Incidents where a DSO attendance may be delayed pending further information / dealt with remotely</th></tr>
<tr><td>Fire call persons reported</td><td>Incidents that may attract media attention</td></tr>
<tr><td>Untoward incidents brought about by a Service failure</td><td>Vehicles impounded by Police</td></tr>
<tr><th colspan="2">Incidents that are likely to require DSO action but maybe conducted remotely</th></tr>
<tr><td>Crew staff assaulted</td><td>Staff ending O/T early unplanned</td></tr>
<tr><td colspan="2">Crews requiring assistance following a traumatic / distressing call</td></tr>
<tr><td colspan="2">Crew staff injured on duty – e.g. back injury or needle stick injury</td></tr>
<tr><td colspan="2">Delayed hospital turnaround times / under pressure / requesting diverts</td></tr>
<tr><td colspan="2">Vehicle off the Road (no vehicle, breakdowns, staff lateness, singles)</td></tr>
<tr><td colspan="2">Staff reporting sick on duty or booked into a hospital</td></tr>
</table>