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

Author/Reviewer: Control Services Staff Officer

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Amendment History			
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20/01/2017	3.9	Snr QAM	Layout. Amendment to Protocol 1 – additional instructions to managing SMS/Text Talk calls. Amendment to Procedure 2 – EMDs to note delay due to using LL Amendment to Procedure 3 change "Section c" TO Procedure 3) Amendment to Procedure 18 –to include conferencing the HEMS paramedic into a call. Amendment to Procedure 19 – As above Addition to Procedure 21. Updates to job titles in Introduction.
22/12/2016	3.8	Staff Officer	Amendment to protocol 15 – addition of 2.3 Amendment to protocol 11 - 3.2.1/3.2.2 Merged to 3.2.1 - 'Foetal heart rate abnormalities'
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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 (Control Services and Sector Services)** have overall responsibility for core operational delivery.

4.4 The **Head of the Emergency Operations Centre** 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.

4.6 **General Managers, (GMs), Watch Managers (WMs) and Area Controllers (ACs** 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 lifesaving instructions.

4.8 **Clinical Hub Clinicians** assist with clinical queries, including – but not limited to – patients who have pre-existing care plans, or complex medical needs.

4.9 **Mental Health Nurses** assist with the triage and management of patients presenting with Mental Health needs.

4.10 **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 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 (e.g. 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. **If an EMD has difficulty finding a location, using both gazetteer and mapbook, assistance must be sought from the Area Controller – Call Handling (Call Taking Manager CTM) or Call Handling Supervisor (CHS). Under no circumstances will the EMD advise the caller to find out the location and call back – the EMD must stay connected to the caller whist they attempt to find the location details. The call must not be quit due to the inability to find a location.**

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 (requested as a direct dial number from the caller) should be noted in the 'Transport Contact' tab.

If the patient's number is not presenting, an origin number should be obtained for the patient and noted in the patient telephone number field. Where possible EMDs should attempt to convert these calls to a 1st or 2nd party call to obtain a more accurate triage.

5. Roaming Calls

5.1. It is possible to make a 999 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 eastings or northings 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, but must take particular care to record all details.

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 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**.

6.5 Case Entry will be completed as normal except that the answer to the caller party question will be entered as fourth party regardless of who is making the call

6.5.1 The appropriate chief complaint should be selected.
6.5.2 Initially, all answers to the key questions will be entered as “unknown”
6.5.3 Once Key Questons have been completed the EMD will then use the “Delta Override”
6.5.4 Enter “SMS Text Message Delta Override” into the Special Instructions” field
6.5.5 PAIS must be given and will MPDS PDIs which offer medical or safety instructions. The closing message should be:

“I need to hang up now to take another call. I have organised help for you. Put away any family pets. Help will be arranged as soon as possible but this may take up to XX minutes (appropriate Surge timescale) to be sent. If his /her condition worsens in any way, contact us for further instructions”

6.6.1 Key recommendations for managing these calls are:

6.6.1Listen carefully to information passed by the relay assistant from the first text message; it might contain both location and incident details.
6.4.1. Ask the questions as if you are talking directly to the caller.
6.4.2. Ask no more than two questions per message.
6.4.3. 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.
6.4.4. Try not to ask for the same information more than once.
6.4.5. Ask for the postal area, street name or local landmarks, rather than for a postcode.
6.4.6. 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 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 6.5.1. – 6.6.6.).

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 Telematics 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 ensuring all pertinent information is recorded as free text, such as:

- Relevant Crew Safety
- Patient care
- Access information

1. Connection

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 It is recognised that in many cases a number of callers may 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 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 first 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, delay Language Line" 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 the 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 Area Controller – Call Handling (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. Control Services Staff (other than Call Handlers) connecting to Language Translation Service

5.1 Where staff (Sector Dispatch or Clinical Hub for example**)** are required to call back a caller who requires translation services, the actions from section 3 will be followed.

6. Connecting VCS to Language Translation Service

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

6.2 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.

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

7 Issues

7.1 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 Exchanges 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 three 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 or let us know if they wish to cancel.

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. If specific information was obtained and the CP operator passes that to the EMD then the appropriate protocol should be selected. However, the nature of the termination of the call (any suggestion of sudden collapse etc.) should be considered as to whether the "Life Status Questionable" option on Protocol 32 would be more appropriate.

2.7 In the event no CLI location is presented and CP does not know any subscriber details the EMD must discuss with the CHS on whether a RIPA request should be made. If it is not, 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 procedure 3 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 three 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 answered though MPDS.
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'.

3.10 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 information from the CP the closed event should either be updated that there is a lack of subscriber's information (and source/reference of the update) , or re-opened and populated with subscriber's details so that an ambulance resource can be dispatched

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 three 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 / Surge 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 which 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 WM for the following actions to be completed.

6.6 The WM is to contact the Metropolitan Police Service (MPS) METCC pan London supervisor desk on 0208 721 7945and 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 calls, from a member of the public, that the patient may have meningococcal septicaemia (meningitis), or where symptoms of possible meningitis are given, must 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 of the 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 The EMD must then select the determinant 26A12 from the list of Alpha level determinants and the call will receive a Red response.

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

3.4 If the call is from a Health Care Professional (HCP) it should be triaged using Protocol 35 and EMDs must select "Meningitis" in response to Key Question number one "What is the reason for the admission?"

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 as follows:**

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 If the patient reports that they are vomiting blood (a Red 2 response on Protocol 21 (Haemorrhage/Lacerations) then that protocol should be used. If the patient has chest pain, then Protocol 10 should be used, but if the response priority is less than C1, the call should be completed as above on Protocol 26.

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

2.5.1 The patient's name.
2.5.2 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 Neonatal Transfer Service (NTS) 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 NTS.

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. Incubators

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

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

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

5. Issues

5.1 Any problems, concerns or issues must be brought to the attention of the Head of Patient Transport Service responsible for NTS, in hours by pager message and by e-mail out of hours.

1. Requests for Advice / GP Attendance

1.1. It is recognised that members of the public will call 999 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 a C4 response, and, if no exclusions apply The call may be given the C4 closing phase which includes being referred to NHS 111

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 for further assistance or referral to NHS111.

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 a clinician 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. Inform the caller of this fact, particularly if a lower priority call as responses can be cancelled for other incidents.

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, if in any doubt re-triage the call. EMDs should ask "Tell me exactly what happened", in case more information is available, and make their own decision as to the appropriate protocol for triage.

3.2 If the patient's condition has is reported as having changed in **any way** the event must be re-triaged. EMDs should read the details of the previous calls to confirm if information given during the call is new information, even if callers say that the patient's condition has not changed. The call can then be re-triaged accordingly.

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 and viewed as a means of reinforcing if the call was originally taken correctly.

4. HCP ETAs

4.1 When receiving an ETA from an HCP, ensure to differentiate between inter-hospital transfers and GP admission referrals. If a HCP call is out of time, (especially a hospital transfer) and the caller reports the patient must travel, CHub should be involved in the conversation regarding any potential upgrade.

4.2 If an ETA is received from a patient/family member, then the call should triaged through MPDS based on the presenting condition at that time.

1 Free Text

1.1 EMDs should use the free text facility to note the following conditions/information when/if it is mentioned by a caller. This information may influence the decisions regarding the disposition of the call by the CHub and must be communicated.

1.2 EMDs should not ask for this information; the questioning within MPDS should be adhered to, but when a patient volunteers the following information the EMD must record this information in the 'Problem Description' field on the EMD data tab, along with a problem description, i.e. Abdo Pain/Difficulty in Breathing

Patients with Haemophilia	**HAEMOPHILIA**
Patients with Addison's Disease	**ADDISONS DISEASE**
Patients who voluntarily describe themselves as "Steroid Dependent". (This is NOT every patient who states they are on steroids)	**STEROID DEPENDENT**
Patients who have been administered Diazepam, Midazolam or Lorazepam (Benzodiazepines)	Drug Name e.g**. DIAZEPAM**
Potassium Levels	**High/Low POTASSIUM**
Blood Thinners/Warfarin	**BLOOD THINNERS** **WARFARIN**
Patient undergoing Chemotherapy both during and between cycles)	**CHEMOTHERAPY**
Neutropenic	**NEUTROPENIC/NEUTROPENIA**
Recent Surgery < 72 hours ago.	**RECENT SURGERY (description - knee/appendectomy etc.)**
Back Pain aged >55 years	**BACK PAIN >55**
Groin Pain in males (between 12-55 years)	**GROIN PAIN**

1. MPDS

1.1. The majority of 999 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 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 - these must be recorded as a yes to the question of any high risk complications on MPDS:

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 or 37**
2.1.7 Diagnosed Pregnancy Induced Hypertension or pre eclampsia**.**

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 if no High Risk Complication applies

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 but should be flagged to the CTM for referral to CHub.

3. Calls from HCPs

3.1. Any calls received from Midwives or other Health Care Professionals to women giving birth at home/public place should be triaged using Protocol 35. Community Birth Centres are triaged on Protocol 37.

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

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

3.5. EMDs should use as reference the "Midwives Communication Tool" as guidance for language they can expect Midwives to use for both Community Midwives on scene and in a Birth Centre. This will also provide the guidance issued by the LAS to Midwives as to the priorities they should be providing for specific types of calls.

4. Escalation

4.1 An EMD highlighting an obstetric emergency during the process of a 999 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 On MPDS Protocols 4 17 and 30 after asking the Key Question "what part of the body is injured?" EMDs must ask the following question (unless the information is provided by the caller):

"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?"

Any mention of a **dislocation** of a joint must also be included in calls requiring an override.

3. Overriding

3.1 When dealing with injuries where gross deformity or an open fracture or **dislocation** is present, EMDs must select the Bravo override code in ProQA (MPDS). If triaging on protocol 4, a subsequent triage through 30 to gain the appropriate non-referral code is required.

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:

- Upper arm
- Shoulder
- Upper leg / hip
- Knee
- Lower leg

- **Distal Areas Affected:**
- Elbow
- Forearm
- Wrist
- Hand (excluding fingers and thumbs)
- Ankle
- Foot (excluding toes)

5. Dislocations and Swelling

5.1 Dislocations can lead to neurovascular damage and therefore are included under the heading "gross deformity". Swelling to the upper leg is also to be regarded as a gross deformity.

1. Introduction

1.1. This procedure sets out groups of HCPs who are able to authorise a delayed response for a patient, and how these calls are managed.

2. Principles

2.1. The EMD should satisfy themselves that:

The HCP is exercising their own professional judgement.
The HCP has **practitioner** level responsibility for the patient.
The patient and the presenting medical condition fall within the HCP's area of expertise. For example:

- A GP can authorise a delayed response for any type of illness/injury for a patient in their care
- A midwife can authorise a delayed response for a pregnant woman in their care
- Nurse practitioners in a Urgent Care Centre (UCC) 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:

- Community/District nurses for elderly or chronically sick patients for admission to intermediate/hospice care
- Palliative Care (McMillan or Hospice Community Nurses)
- Community Mental Health nurses for mental health patients
- Certain clinically trained ambulance staff (paramedics and EMTs) for patients whom they have assessed
- Physiotherapists / Occupational Therapists / Chiropractors / Optometrists (within their scope of practice)
- Emergency Bed Service (EBS) when booking a delayed response on behalf of a GP or Other HCP
- Dentists

4 Calls from Health Care Professional (HCPs)

4.1 These calls are primarily managed on either MPDS Protocol 35 OR Protocol 37 dependent on the type of journey.

5 Protocol 35 is used for HCP admissions which include:–

5.1 GP admissions from the community (surgeries/home/clinics).
5.2 Patients going to Emergency Departments for investigation.
5.3 Calls from MIU/UCC/WIC where the clinician responsible for the patient is making the call.

6 Protocol 37 is used for:-

6.1 Critical and Immediate Transfers as defined by the current version of the Hospital Transfer Flowchart.
6.2 Other inter-hospital transfers with > 1 hour timescales that are within the LAS contract) special patient groups)
6.3 Mental Health Transfers where the patient is being transferred based on the MH condition.

7 **MPDS protocols 1-31 should be used for**:

7.1 Calls from MIU/UCC/WIC where the responsible clinician is not calling

7.2 Patient at Mental Health facilities who are unwell with something other than a MH related condition

7.3 Hospitals without an Emergency Department or Community Hospital where the responsible clinician is not calling.

7.4 The HCP is not able to take clinical responsibility for the patient e.g. for a family member, or member of the public in the street

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, i.e.: 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.

2.3. If the AED is already with the patient add "**AED with Patient**" 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.

3.5. If the AED is already with the patient add "**AED With Patient**" 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.

2.2. PSPs must be viewed when taking a call, before completion

2.3. Where a minimum response priority is indicated on the PSP EMDs should check the response priority obtained through MPDS and, where this is lower than the minimum indicated, contact the CTM/CTC to contact CHub or an Area Controller to change the priority. EMDs must complete the call before this is done, or the response priority will revert to the MPDS determinant priority when the call is completed.

1.0 All NHS employees have a responsibility to ensure that any safeguarding concerns relating to children (all people under 18 years) and vulnerable adults are notified to the appropriate agencies.

2.0 **Safeguarding**

2.1 The LAS has Safeguarding procedures which staff must ensure they are familiar with.

2.2 EMDs, when taking a call may be provided with information, or hear something that raises a safeguarding concern. Staff should not assume that the information will be available to/obvious to an attending crew. EMDs are able to make safeguarding referrals at call handling, by completing the relevant form (LA279 or LA280)**.** It should be noted in the call log along that this has been done along with the cause of the concern.

3.0 Vulnerable Patients

3.1 Any patient who is **alone** is potentially vulnerable. All patients who have Mental Health issues/ history and self-harmers (including threatening) should be regarding as vulnerable. Other potentially vulnerable people are those who are **cognitively impaired** and/ or **learning disabled** and those who are **frail and elderly**.

3.2.1 It should always be established if a patient is **alone** or not, and if so this should be documented in Remarks field. The EMD should also:

3.2.2 Establish how access will be made.

3.2.3 Stay on the line with the patient where possible and ensure that all pertinent information is recorded on the EVA

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

3.3 If a possible collapse behind locked doors has been identified, this should be documented in the remarks field and sent as urgent information and be flagged to the Dispatch Group as MPS are required as soon as possible.

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

4.0 Mental Health Patients.

4.1 Some Mental Health patients are particularly vulnerable and care should be taken, as people in the middle of a mental health crisis **may** not be able to exercise good judgement.

4.2 **Mental Health Units**

4.2.1 When a call is received from a mental health unit, contact should be made with a staff member to confirm if an ambulance is required. It is important that EMDs ensure they clarify whether the patient has any other health issues/clinical needs at the time of the call, which would require LAS attendance.

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

4.2.3 When LAS are attending, EMDs must obtain a location for staff at the unit to meet the crew(s). This is particularly important at night or at any time when attendance is to a secure unit. This will reduce the likelihood of significant delays in attendance to life threatened patients where crews are unable to obtain access to the buildings.

5.0 Self Harm

5.1 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.

5.2 It must always be established if a patent is **alone** and this must be documented in the Remarks field. The EMD should also establish how access will be gained (see above – 4.3 and 4.4)

5.3 If the call is from a 3rd party caller, EMDs should try and make contact with the patient direct to gain current information. If no contact can be made, this should be noted in the Remarks field.

5.4 Stay on the line with the patient where possible and ensure all pertinent information is recorded on the EVA. MPDS indicates that where the patient is threatening self-harm (further self-harm) EMDs should remain on the line if at all possible.

5.5 Patients who have taken overdoses, or are haemorrhaging who are **ALONE** will not be able to call us if their condition deteriorates (reducing/loss of consciousness) for the call to be upgraded. EMDs should remain on the line, or fully document why they are terminating the call and alert the CTM/Dispatch Group to the risk.

5.6 If, during a call, a patient states that they are going to self-harm and terminates the call this must be highlighted to the CTM/Dispatch especially when the nature of the threatened self-harm is likely to have an immediate severe impact, e.g. hanging.

1.0 This procedure applies to all calls where the caller is not with the patient except those calls from the Police received through the CAD Link which are managed through procedures relating to MetDG.

2.0 Calls triaged through a 3rd/4th party may not provide sufficient information to obtain an accurate reflection of the patient's condition and are further hampered by a lack of ability to update or gain further/new information as the call progresses. In all cases EMDs should

- Attempt to obtain a contact number for the patient and note it on the EVA
- The call must be triaged fully with the 3rd/4th party caller and all appropriate and possible PDIs provided.
- It should be established if the patient is ALONE and, if so, note this in the EVA.
- Try and convert to a 1st/2nd Party caller and re-triage.

3.0 Calls for **vulnerable patients** should be considered carefully (See Procedure 16).

3.1 For example,

- calls from a third party where the patient is alone and is vulnerable (including self-harmed i.e. overdose) should be converted if possible. If it is not possible to contact the patient, the Sector and CHub must be alerted to the incident.
- If contact is made with the patient, and they refute having self-harmed and insist they do not want an ambulance: EMDs should not get into a conversation about this, but should complete the call should so that a face to face assessment can be undertaken.
- Calls from Carelines should, where possible be converted. If a patient is reported by the Careline as being alone and immobilised (fallen still on the ground) then this will not be possible if they are alone on scene, but if someone else is there, then converting to a second party call should be attempted.

The above scenarios are not exhaustive.

4.0 The *minimum* **Dispatch Life Support** information that should be provided to 3rd/4th party callers is protocol specific Post Dispatch Instructions, the time-frame of the call response and the worsening instructions. If the caller is in contact with the patient or an appropriate person with the patient, EMDs should attempt to provide full (possible, appropriate and possible) PDIs to the Caller for them to be passed onto the patient.

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 made 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

3. EMD Call Process

3.1 Whilst a call is in progress, the EMD will identify if it meets the criteria in section 2 above.

3.2 The EMD must complete the full MPDS triage and give any appropriate PDI's before transferring the call to the HEMS Paramedic, to allow for any additional HEMs specific triage.

3.3 If PAI's are required the call must not be transferred – the EMD must notify the CHS who will in turn notify the HEMs Paramedic of the call, who can then monitor or request to be conferenced in if the EMD must stay on the line.

1 Introduction

1.1 The APP group are targeted at acute calls in order to get the advanced skills to the scene quickly when needed.

2 Targeted Calls

2.1 To target the skills of the APP group appropriately, the APP based in EOC should be made 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

3 EMD Call Process

3.1 Whilst a call is in progress, the EMD will identify if it meets the criteria in section 2 above.

3.2 The EMD must complete the full MPDS triage and give any appropriate PDI’s before transferring the call to the HEMS Paramedic, to allow for any additional HEMs specific triage. If the HEMS paramedic is unavailable the call may be transferred to the APP.

3.3 If PAI’s are required the call must not be transferred – the EMD must notify the CHS who will in turn notify the APP of the call.

1.0 When a patient is unwell in a prison it may be difficult, due to the communications issues for Prison staff in secured areas, for sufficient information for the accurate

1.1 To reduce the potential delays prison staff will use a short code to indicate that they believe the patient's condition is immediately life threatening.

2.0 Staff should:

2.1 Enter the location as provided, **confirming the access point** and, if available on the Gazetteer, ensuring the **specific** access point (Gate) is selected.

2.2 Select Code Blue/Code 1(provides a Red 1 priority) **or** Code Red/Code 2 (Red 2 priority) from the "EMERG" drop down box in CP. ProQA will not open or be accessible if either code is selected.

2.3 Type any additional diagnosis information in the "Problem Description" field

2.4 Provide PAI's via the MPDS Card set if the caller is with or accessible to the patient

2.5 Confirm the details (read back) to the caller and provide the appropriate and possible PDIs (minimum of the "worsening instruction".

2.6 Complete the Event/call, passing the Event number to the caller

2.7 Where a Code is not used AND there is no indication from the caller that the patient may be life threatened, the call should be processed as normal through the appropriate protocol.

1 This procedure applies to call within the LAS area which is initially taken by other UK ambulance services.

2 UK ambulance services use both MPDS and NHS Pathways to triage 999 calls.

2.1 When a 999 call is received from another service using MPDS EMDs should

2.1.1 Obtain the Location of the incident
2.1.2 Get the Origin caller telephone number (and patient contact telephone number if different and available)
2.1.3 Proceed through MPDS questions
2.1.4 EMDs must also ask "Is there any other information, including relevant medical history and medication relating to the patient or incident?". This should be noted in the "Problem Description" field.
2.1.5 The other Ambulance Service's determinant should be confirmed. If this differs from the one obtained by LAS, then clarity should be sought as to why. If the response priority differs and the LAS' is higher, then that should be used. If the A/S passing the call has a higher response priority, then the CTM should be consulted to see which should apply (to check if the correct triage has been obtained, or a local decision by the other service as response levels is the cause). Normally the higher priority from either source should apply

2.2 For Ambulance Services using NHS Pathways EMDs should process the call normally through MPDS (as above) and on completion of triage confirm the response priority of the other service. If this is lower or the same as the LAS response, no action is required. If the other services' response is higher, clarity should be sought as to why and the CTM involved to match the higher priority. Normally the higher priority from either source should apply

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 for a patient 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 some countries place the door number after the street name.
   2.4. For the patient telephone number ensure that you also get the country dialling code where possible.
   2.5. Document in remarks the language normally spoken by both the caller and the patient.

3. **CTM / CHS**
   3.1. The CTM and / or CHS should assist the call taker as required to confirm the location of the patient.

4. **DDS**
   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 in the GR file
   4.2. Where no number is listed for that country, then the Clinical Hub may be able to assist in identifying a number.

5. **Passing the Call**
   5.1. Contact the relevant control, bearing in mind the following:
      5.1.1. The call centre may not be able to take the call in English. Consider Language Line to assist (English is required within the EU).
      5.1.2. The call centre may not be a specific ambulance control. It may be police, fire, or a combined emergency services call answering service.
      5.1.3. Identify yourself as the London Ambulance Control in the UK, stating that you have an emergency call to pass to them.
      5.1.4. Pass all details that we have been able to get.
      5.1.5. Take a reference number for the call, or the initials of the person who took the details
      5.1.6. Record all of the details, including the number used to contact the relevant control as supplementary information in the event chronology.
   5.2. Close the call with the disposition INTAMB

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.

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 WMs will monitor watch and produce a report for the Head of 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 WMs will monitor watch and produce a report for the Head of 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

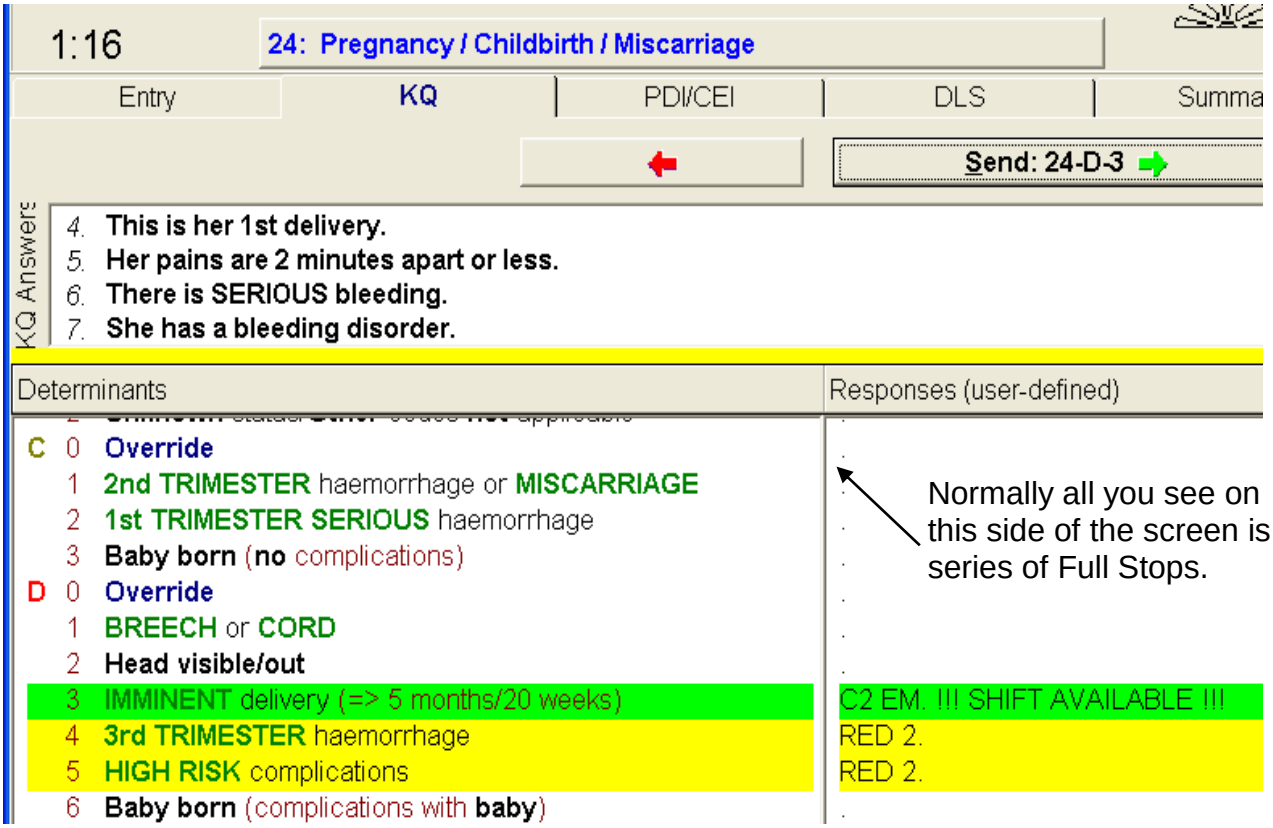
112	The Emergency phone number recognised in the EU
999	The Emergency phone number in the UK
AED	Automated External Defibrillator
AEU	Ambulance Emergency Unit
ALS	Advanced Life Support
BBA	(Baby) Born Before Arrival
NTS	Baby Emergency Transfer Service
BLS	Basic Life Support
CAD	Computer Aided Dispatch
Card Set	Card index version of MPDS
CBRN	Chemical, Biological, Radiological, Nuclear
CHub	Clinical Hub
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
CTM	Area Controller – Call Handing
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
METCC	Metropolitan Police Command and Control
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
NICU	Neonatal Intensive Care Unit.
NSY	New Scotland Yard
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
WM	Watch Manager
WIC	Walk in Centre

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

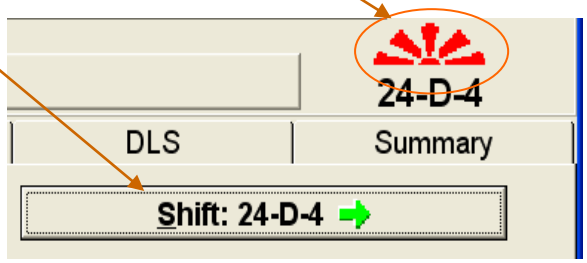
Therefore more than one determinant is relevant, this patient is in imminent delivery (D3), she is haemorrhaging (D4) and she has a blood disorder (D5).
ProQA highlights D3 in green simply because it is the highest in the Numbering sequence (7 low —1 high) it also highlights D4 and D5 in yellow as they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

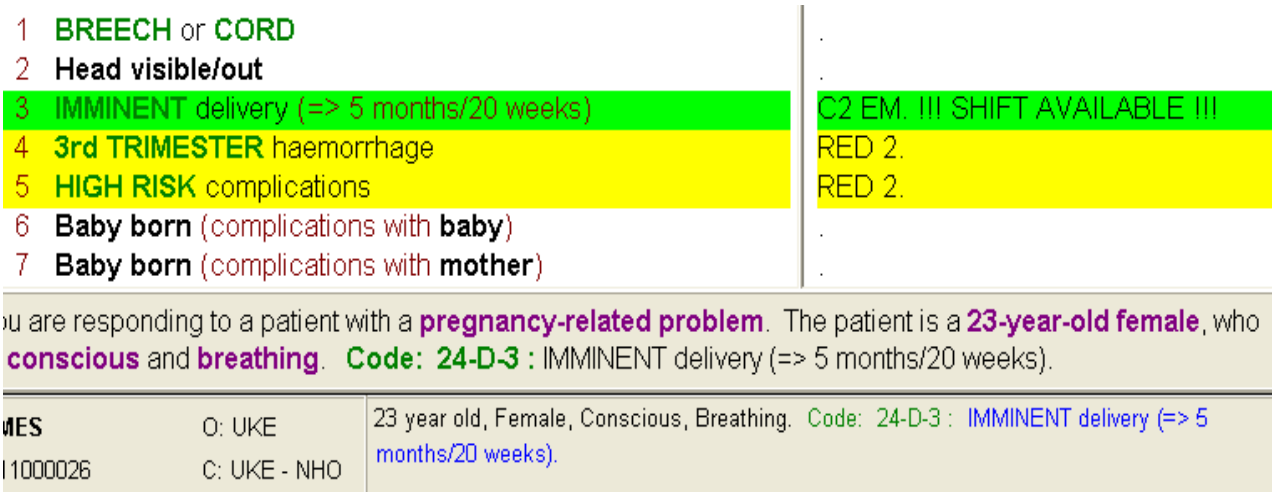
Note: in these instances the Response code has been input to assist in selecting the Highest LAS response for the call.
Sometimes, due to the size of the screen, only the determinant highlighted in Green will be visible, however the “SHIFT AVAILABLE” should be a prompt to scroll down and check.

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.