London Ambulance Service NHS
NHS Trust

Procedure for the Conveyance of Patients

DOCUMENT PROFILE and CONTROL.

Purpose of the document: is to ensure that the LAS provide patients with optimum care based upon their clinical needs.

Sponsor Department: Education and Development

Author/Reviewer: Head of Education and Development. To be reviewed by Sep 2011.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
25/09/2008	2.1	Educational Governance Manager, Head of Governance, Medical Director	Revised
17/02/2006	2.0	Head of Education and Development	Revised
01/09/2004	1.0	Commander west Sector	Revised

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

For Approval By:	**Date Approved**	**Version**
Senior Management Group	29/09/08	3.0
Ratified by:		

Published on:	**Date**	**By**	**Dept**
The Pulse	01/10/08	Records Manager	GDU
Internet	10/07/09	Records Manager	GDU

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
OP/031	Policy for Consent to Examination or Treatment	
	JRCALC Clinical Practice Guidelines	
OP/011	Minor Injury Units see Procedure for Transporting Patients to Minor Injuries Unit / Walk-in-Centres	
LA004	Patient Report Form (PFR)	
TP/003	Policy Statement of Duties to Patient	

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

Introduction

The London Ambulance Service (LAS) responds to over 945,000 emergency and urgent calls in a year (2007-2008). Around 76% are conveyed to hospital or another appropriate destination. The LAS is committed to providing those patients with optimum care based upon their clinical needs.

For a number of reasons, around 24% of the calls that are responded to result in no patient being conveyed. The LAS is committed to providing these patients, wherever possible, with alternative assistance appropriate to their clinical needs.

Objectives

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

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

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

Procedure

1.0 Patient Destination

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

1.2 The most senior clinician on scene will consider both the clinical needs of the patient and the facilities available at local hospitals. These factors may influence the choice of destination. Where a designated destination has been provided, the patient must be conveyed to the precise destination stated upon receipt of the call details. Should subsequent assessment reveal a change in treatment priorities, the initial destination choice may be revised in the best interests of the patient. This decision should take into account the wishes of the patient, especially patients in palliative care whose designated destination may be a hospice.

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

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

1.5 Patients attended as the result of emergency calls should in most cases be conveyed to the receiving Emergency Medicine Department that can be reached soonest. There are certain exceptions to this:

- where the nearest/local Emergency Medicine Department does not receive a certain category of patient, e.g., paediatrics, these patients must be conveyed to the next appropriate Emergency Medicine Department.

- when the condition of the patient suggests that rapid access to specialist care will require that they be directly conveyed to a hospital providing that speciality, e.g., Major Trauma, Neurosurgery & Hyperacute Stroke Services.

- maternity and confirmed STEMI cases, which should be managed according to current specific protocols.

- patients whose condition justifies the use of an alternative referral pathway, which could include conveyance, e.g., to a minor injuries unit, or non-conveyance, e.g., arrangement of a visit from a community nurse / other primary healthcare practitioner.

1.6 Patients receiving ongoing treatment for a condition may be conveyed to the hospital where their regular treatment is provided on the provision that a more serious or life-threatening clinical condition does not take precedence (see 1.1). On-scene requests for conveyance to a destination other than the appropriate Emergency Medicine Department must be notified to the Emergency Operations Centre (EOC)/ Urgent Operations Centre (UOC). In all such cases, staff must ensure that the best interests of the patient are assured, and no significant clinical risk arises. The Patient Report Form (PRF) should be filled out and at least two full sets of patient observations recorded.

1.7 Patients who satisfy the criteria given in current LAS protocols may be conveyed to the nearest Heart Attack Centre or local Minor Injuries Units (MIU) that have a formal arrangement to receive LAS patients (for Minor Injury Units see Procedure for Transporting Patients to Minor Injuries Unit / Walk-in-Centres OP / 011).

1.8 An on-scene Doctor or other Health Care Professional (HCP) with responsibility for the patient may make a request for the patient to be taken to a designated destination other than the nearest Emergency Medicine Department. Staff should comply with the request, informing EOC/ UOC before leaving scene, and recording the name and details of the doctor/HCP on the Patient Report Form (LA4) (see 1.1 & 1.7)

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

2.0 Removal from Scene

2.1 Patients must be removed from scene to the ambulance using the most expedient route and method available based upon their clinical needs. While recognising the core mobility classifications listed below in 2.4, it is essential that staff constantly reassess the patient's condition to ensure the method of removal is compatible with minimising any risks for the patient.

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

2.3 Staff must ensure that all efforts are made to protect the privacy, confidentiality and dignity of their patients. These not only reflect the rights of patients as individuals, but treating all patients with courtesy and consideration significantly helps them to feel safe and secure. Similarly, attention given to the positioning and comfort of patients during the removal and subsequent journey only adds to enhance the overall patient experience.

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

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

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

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

2.5 Staff must determine the mobility classification of emergency patients based upon their clinical assessment, and the requirements of current clinical protocols and guidelines. Once again, the potential risks for patient harm caused by inaccurate and inadvertent patient/ staff actions (as highlighted in 2.2) cannot be overemphasised.

2.6 Where a mobility classification has already been determined, e.g., non-urgent journeys, that classification must be adhered to as the minimum requirement. Where there is a significant discrepancy between the classification given and the assessed clinical needs of the patient, the details should be noted on the PRF/ PTS 1.

2.7 Patients with mobility aids should be allowed to use and take these with them if they so wish and if deemed appropriate by staff (see 2.1). Patients in wheelchairs must be transferred to a fixed seat or trolley bed once on board the ambulance, and if the wheelchair is to be taken it must be safely stowed.

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

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

2.10 Should a patient continue to act against the advice given, EOC/ UOC should be informed at the earliest convenient opportunity, and the details recorded on the PRF/ PTS 1. This information should also be included in the handover to staff at the receiving destination. All efforts must be made to ensure that any potential clinical risks that are a result of the patient's actions contrary to advice are kept to a minimum.

2.11 The decision as to whether/ how many friends/ relatives travel with the patient rests with the crew, and must be based upon both the patient's needs and the practicalities of the patient's treatment. This number may be exceeded in the case of professional escorts responsible for the patient's ongoing treatment and welfare, but in both cases the vehicle's maximum loading capacity must be observed.

2.12 Where possible, patients below the age of 16 should be accompanied by a parent or guardian. When this is not possible, either a teacher or other responsible adult can accompany the patient in loco parentis, or, the attendant will act in loco parentis until this responsibility is passed to the person receiving the patient. There is no minimum age at which a child /children maybe left unsupervised. However, ambulance staff must convey the child /children or contact EOC/ UOC to arrange for the police to attend and assume responsibility. (See Procedure for Actions on Scene Indirectly Related to the Patient - Safeguarding of Children).

3.0 En Route

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

3.2 The attendant must travel in the back of the ambulance with the patient. If a number of health care professionals are escorting the patient, the attendant may travel in the front of the ambulance, but must be prepared to assist the escorting team if required.

3.3 If a patient recovers en route to hospital and becomes adamant that they wish to discontinue the journey, staff must make determined and tactful attempts to persuade the patient to continue. Should this prove unsuccessful, the ambulance should be stopped and EOC/ UOC informed. If there is no competent person accompanying the patient and the patient is incapable of leaving the scene unaided, or there is concern for the patient's welfare, police attendance should be requested. The crew should remain with the patient until the police arrive and on hand over given the completed pink copy of the PRF (see Policy Statement of Duties to Patient - for a definition of competency). If there is a competent person accompanying the patient, that person should be given the pink copy of the PRF and advised to take the patient home or to a place of safety, and to seek medical attention should the patient's condition persist or deteriorate.

4.0 Upon Arrival

4.1 Upon arrival at the destination the patient should be removed from the ambulance using their designated or assessed mobility assistance requirements as a minimum.

4.2 If a discharged patient has been conveyed home, but there is, in the professional opinion of the crew, an inadequate level of support to maintain the patient's welfare, the crew should inform EOC/ UOC before potentially returning the patient to the hospital.

5.0 Non-Conveyance

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

5.2 Ambulance staff must never refuse to take a person for whom an ambulance has been assigned to hospital. Ambulance staff should not attempt to dissuade a person who wishes to go to hospital from doing so nor should they negotiate – but should assume that in the majority of cases conveyance is required.

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

5.4 Staff should remain mindful that they can seek advice from EOC/UOC at any time, with further assistance provided by the Clinical Support Desk. The desk is staffed by experienced paramedics who have been trained to support staff with patient related clinical problems, as well as any aspect of patient assessment or treatment. Equally, the advice and/or assistance of an Emergency Care Practitioner (ECP) on scene may be requested via EOC/ UOC (See Referral Guideline – Referring Patients to Emergency Care Practitioners)

5.5 Should a patient decline conveyance to hospital following ambulance assistance or treatment, staff should base their attempts to persuade the patient to travel upon their clinical needs. Where the patient continues to decline conveyance despite appropriate advice, EOC/ UOC must be informed and all relevant information recorded on the PRF and LA1, including a full set of patient observations. Where a patient lacks the capacity to make an informed decision crews may act under common law to affect conveyance (see current Policy for Consent to Examination or Treatment). Dependant upon the circumstances and condition of the patient:

At a private address:

- the patient should be left in the care of a competent person who has access to a telephone and details of the patient's GP. They should be instructed to contact the patient's GP or recall the ambulance service if the patient's condition deteriorates. The pink copy of the PRF should be left with a competent individual who should hand it to the patient's GP or other HCP.

- if there is no competent person to take responsibility for the patient, the crew must attempt to establish the name and telephone number of the patient's GP. EOC /UOC must be requested to contact the patient's GP, and will inform the crew of the GP's ETA. If the crew are returned to station or given another call, and remain concerned about the welfare of the patient whilst waiting for the GP, they may request police attendance.

In a public place:

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

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

IMPLEMENTATION PLAN	
Intended Audience	All Operational staff
Dissemination	Available to all staff on the Pulse
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	Annual CPD updates and via Team Leaders
Monitoring	Staff use and compliance with the content of this policy will be monitored by Team Leaders as part of their day-to-day role. In addition, the bi-annual Operational Workplace Review will also help identify any issues associated with the practices of staff, which can be further developed through the Personal Development Review process as necessary.