Procedure on Actions on Scene DIRECTLY Relating to the Patient including the Recognition of Life Extinct and the Management of the Deceased.

Introduction

Operational issues that relate directly to patients can be a frequent occurrence for ambulance staff when attending the scene of a call. Some issues may require liaison with other agencies or services.

This procedure aims to provide guidance for ambulance crews and is in two parts. **Part A** aims to capture the most common of these situations and provides direction for staff on how they should be managed. **Part B** instructs staff on the Recognition of Life Extinct procedure, (in accordance with JRCALC National Clinical Guidelines 2006), the issues that may arise and the management of those issues.

Objectives

1. To ensure that staff are appropriately informed of the action to be taken on scene, in the most frequently occurring issues that are directly related to the patient.

2. To ensure that staff are appropriately informed in the recognition of life extinct procedure and the management of deceased patients.

3. To ensure that adequate support is available for staff to call upon when working in vulnerable situations.

4. To minimise risks that can occur whilst on scene.

Procedure Part A

1.0 Locating a Patient

1.1 On arrival at the call location, the mobile data terminal (MDT) should be updated and the time recorded on the Patient Report Form (PRF). The time of arrival at the patient must also be recorded when completing the PRF.

1.2 Ambulance staff arriving at the location given via the MDT, yet unable to locate the patient must contact Emergency Operations Centre (EOC)

with this information and commence an ‘area search’. During the area search, EOC will, attempt to make contact with the caller to confirm the location. The LAS has a responsibility to take all reasonable steps to locate the patient.

1.3 If despite all efforts the patient is not found, EOC must record on the Emergency Call Receipt form (AS1) ‘area search, no trace’ along with a record of attempts to “ring back” with the resulting outcome. Ambulance staff must record area search no trace (code 9013) on the PRF.

2.0 Threatening Behaviour

2.1 All ambulance staff must proceed with caution when confronted with potentially violent situations and must place their own safety first. If faced with threatening behaviour, ambulance staff should make all efforts to diffuse the situation remaining calm, respectful and polite at all times. Further guidance is available in the Violence Prevention Procedure H&S/012a.

2.2 If unsuccessful and the situation persists or escalates, staff should withdraw and seek assistance from EOC. Form (LA277) must be completed, please refer to the Incident Reporting Procedure H&S/011 for additional guidance.

3.0 Protection of Patient

3.1 Although the personal safety of the ambulance crew is priority the safety of patients and others at scene remains paramount. This may, for example, include the protection of the patient during a difficult extrication where cutting equipment is in use. Ambulance staff must inform the patient of the intended actions to be taken which may affect the patient, the situation or the outcome in any way.

4.0 Assistance of Other Health Care Professionals

4.1 The first operational staff member on scene should assess the need and request if appropriate, further medical assistance for example on call clinical advice, or requesting the attendance of HEMS or BASICS doctors.

4.2 The EOC should be contacted and given a report of the incident to enable them to liaise with the appropriate service.

4.3 Staff should make themselves familiar with local alternative health or social care pathways in order to provide the most appropriate Treatment for patients – see OP/011 Transporting Patients to MIUs / WICs for a complete list of referral guidance notes.

5.0 Recognition and Reporting of Abuse

5.1 Staff are responsible for reporting all instances of abuse which they are made aware of. In the case of a child any **suspicion** of abuse must be reported. Vulnerable adults, notably the elderly and disabled may also be subject to abuse. The appropriate forms must be completed and the incident reported as outlined in paragraph 5.2

5.2 If staff suspect a child is being abused, TP / 018 Suspected Cases of Child Abuse Procedure must be implemented. Additional guidance is available in the National Clinical Guidelines.

If staff suspect an adult is being abused, TP / 019 Suspected Abuse of Vulnerable Adults Procedure must be implemented. Additional advice is available in the National Clinical Guidelines.

The situation must be documented on the PRF and the appropriate Child Protection Report Form (LA279) or Protection for Vulnerable Adults Form (LA280) must be completed. The receiving A&E Nurse / Doctor must be notified at hand over of the competition of a referral form and the circumstances surrounding the patient. The receiving clinicians name and designation must be recorded on the PRF.

5.3 If the victim of suspected abuse is the patient but not conveyed, or the victim is not the patient at the location, ambulance staff must complete the relevant form (LA279/ LA280) and contact EOC at the earliest opportunity to enable them to notify the police / social services of their suspicions and / or evidence. All EOC actions will be recorded on the call receipt form (AS1/AS2) and an entry made in the EOC Occurrence Book.

6.0 Conveyance of Children

6.1 It is good practice for a responsible adult to accompany a child to hospital and ambulance staff should make every effort to ensure that this happens. However, if this is not possible ambulance staff must convey the child in the normal manner, and inform EOC that the child is unaccompanied. EOC will document this on the call receipt. Staff must obtain as much information about the patient as possible including relevant medical history to ensure a full hand over on arrival at the hospital.

6.2 Before examining or treating a child ambulance staff must gain consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Children under 16 years of age have the right to provide independent consent proportionate to their competence (although their parents will ideally be involved). In cases where children do not have the capacity to consent for themselves, parents (mother only if the parents are not married) or someone with parental responsibility must give consent on the child's behalf. If the

situation is deemed life threatening and the parent/ person with parental responsibility is not available the attending ambulance crew must act in the patient's best interest. If a competent child consents to treatment, a parent cannot override that consent. Legally, if a competent child refuses treatment a parent/person with parental responsibility may override that decision – see OP / 031 Policy for Consent to Examination or Treatment for more information.

7.0 Scene Environment

7.1 Ambulance staff have a responsibility to record on the PRF and report to the hospital staff during handover, any concerns they may have about the patients home environment e.g. cold, damp, unsanitary conditions, no food provisions or a dangerous appliance or structure.

7.2 When the patient is being conveyed to a home address which is found to be unhealthy or unsafe it should be reported to EOC as soon as possible before leaving the premises. EOC will decide on what appropriate action to take, e.g., locally agreed access pathways to social services and where cases of child or adult abuse are suspected, implementing TP/018 or TP/019.

8.0 Cultural Awareness

8.1 LAS staff are constantly in contact with patients from different cultures. Staff must treat all patients equally affording them courtesy, respect and politeness at all times. Under no circumstances should a patient be treated less favourably than another on any grounds. This is in accordance with the IHCD Training Manual and LAS Equality and Diversity Policy Statement and Employment Policy.

9.0 Dealing with Patients when there are Communication Difficulties

9.1 Due to the diverse population that the LAS serves it is probable, ambulance staff will come into contact with patients where there are communication difficulties. These difficulties may cause the patient further distress and anxiety, thus limiting patient assessment. Support and guidance is provided for ambulance staff through the LAS Multi Lingual Emergency Phrase Book and Ethnic Health and Cultural Awareness Information Handbook. In extreme situations, where medical circumstances dictate, staff should contact EOC who can access an interpreter. Operational ambulance staff have access to Language Line via their personal Emergency Crew Assistance (ECA) mobile phone. Communication difficulties may come in one of many guises and LAS staff must make every effort to ensure that the patient is involved in all decisions surrounding the aspects of their care.

10.0 Patients who have made an Advance Directive / Living Will

10.1 An advance directive can be made by a patient that has a degenerative illness that will eventually render them unable to consent for themselves or unable to communicate specific wishes regarding treatment they do not want to receive. An advance directive is binding if:

- The person making the directive was 18 or over at the time it was made and had the necessary capacity
- It specifies the specific treatment to be refused and the circumstances in which the refusal is to apply
- The advance directive has not been withdrawn at a time when the patient still had the capacity to do so.
- A lasting power of attorney has not been appointed since the directive was made.

Advanced directives can be oral or in writing, however it will only apply to life sustaining treatment if it is in writing, is signed, witnessed and contains a statement that it is to apply even where there is a risk to life.

10.2 In an emergency or where there is doubt about the existence or validity of an advance directive, treatment can be provided that is immediately necessary to stabilize or to prevent deterioration until such a time that the existence of the advance directive can be established..

11.0 Dying Declaration

11.1 On occasions patients who are dying, make a statement which could be relevant to:

- Their cause of death.
- The circumstances of their death.
- Personal wishes at the time of death, possibly concerning property or their feelings.

This information may be used in court if the patient's death is connected with an illegal act,

11.2 If a patient knows they are dying and makes a statement, ambulance staff should write down and record where possible, what was said and the patient should sign the declaration. Any declaration must be given to the police along with a statement from the ambulance staff concerned.

Procedure Part B

12.0 Patients Not for Resuscitation

12.1 An ambulance may be called to a terminally ill patient where death has occurred or is imminent. A decision may have been made by either the patient and / or the patient's medical team that resuscitation should not take place. This information should have been passed to the crew via the mobile data terminal if the do not attempt resuscitation (DNAR) order has been registered with the LAS. However if this is not the case, resuscitation must be attempted until a time where the appropriate documentation is available. The National Clinical Guidelines 2006 allow for resuscitation to be discontinued

in situations where a patient's death is expected due to terminal illness. Under these circumstances the attending ambulance crew must have sufficient evidence to support their decision. Confirmation can be received verbally from the GP or other appropriate practitioner. In the event of resuscitation not being commenced or resuscitation attempts being terminated form LA3 (verification of death) must be completed. Documentation of this decision should be in accordance with the JRCALC National Clinical Guidelines 2006. In situations where resuscitation attempts have been terminated, endotracheal tubes and cannula's must be left in place. If for any reason they are removed, justification for this action must be documented on the PRF.

13.0 The Unexpected Death of a Patient at home or place of residence

13.1 When an unexpected death occurs at home or place of residence, the attending ambulance crew must complete form LA3. The crew must contact EOC to request the attendance of the police. The police must be informed of all unexpected deaths as it is their responsibility to establish if the death is suspicious and to liaise with the Coroner's office. The Coroner must be informed of all deaths in their jurisdiction, however not all deaths will result in an inquest. A copy of the completed PRF and LA3 must be handed to the attending police officer and the advice leaflet should be offered to the bereaved. LAS staff are then free to leave scene.

13.2 In situations where there is a responsible adult on scene and the crew feel in their professional judgement they are in a position to leave that person with the deceased the person's name must be documented on the PRF and the LA3. A copy of each must be handed to the person and they must be instructed to hand the documentation to the attending police officer. The crew must be absolutely confidant that this process

will be followed before leaving scene. On leaving scene EOC must be informed of the crew's actions and the name of the adult left at the scene.

13.2 Patients who are recognised as deceased on private premises must not be removed by the LAS. **Under no circumstances should a deceased patient be removed from the scene with out authority from the Coroner.**

14.0 The Unexpected Death of a Patient in a Public Place

14.1 Once ambulance staff have recognised life to be extinct copies of the completed PRF and LA3 must be handed to the attending police officer. If the police are not on scene their attendance must be requested via EOC. All efforts must be made to conceal the body from public view. LAS staff must remain on scene until the police are in attendance, once the relevant information and documentation has been handed to the attending police officer the crew are then in a position to leave the scene.

It is not the responsibility of the LAS to remove deceased patients from scene. In exceptional circumstances and only when the attending police officer has liaised with the Coroner's Office, LAS crews may assist in removing the
deceased to a public mortuary. The destination of the patient will be determined by the Coroner's office. **Under no circumstances should a deceased patient be removed from the scene without authority from the Coroner.** If an LAS crew have been asked by a police officer or doctor to remove the deceased from scene, assurance must be sought to ensure that the Coroner has been informed and document on the PRF and LA3 the shoulder number of the police officer authorising the removal.

15.0 Death of a Patient in which there are Unusual or Suspicious Circumstances

15.1 Where there are unusual or suspicious circumstances, staff must take all reasonable precautions to preserve the potential crime scene, and await the arrival of the police.

16.1 Expected Death of a Patient in their Home or Place of Residence

16.2 An ambulance may be requested to attend an expected death in a patient's home or place of residence. If the patient has seen their own General Practitioner (GP) in the 14 days preceding death, the GP may feel they can issue a medical certificate for the cause of death (MCCD). If the patients own GP is unavailable contact the district nurse (DN) or specialist palliative care team (SPCT) caring for the patient and request their attendance. If there is no DN and or SPCT involvement, the police must be called. A completed copy of the PRF and the LA3 must be

handed to the attending DN / SPCT nurse or police officer. The LAS crew may then leave the scene. In situations where there is a responsible adult on scene refer to the procedure outlined in paragraph 13.2,

17.0 Sudden Unexpected Death of an Infant

17.1 In the event of an ambulance being called to attend the death of an infant the Medical Directors Bulletin dated 21st February 2006 must be adhered to. In summary:

- All infants must be resuscitated unless it is clear that the infant has been dead for some time,
- The infant must be conveyed to the nearest Accident & Emergency department.
- If it appears that the infant's condition is unequivocally associated with death in accordance with JRCALC national clinical guidelines, the crew must remain on scene and request urgent police attendance.

References:

OP / 011 Transporting Patients to MIUs / WICs and Referrals to other healthcare services.
OP/010 Procedure for the Maintenance of the High Risk Register.
OP / 028 Procedure for Specific Named Patient Protocols and No Resuscitation Orders / Advance Directives.
OP / 031 Policy & Procedure for Consent to Examination or Treatment.
TP / 018 Suspected Cases of Child Abuse Procedure
TP / 019 Suspected Abuse of Vulnerable Adults Procedure
LA52 Incident Reporting Procedure
BMA The Mental Capacity Act 2005-Guidance for health professionals
DoH Guidelines – Working Together to Safeguard Children
LAS Ethnic Health and Cultural Awareness Information Handbook
LAS Equality and Diversity Policy Statement and Employment Policy.
LAS Multi Lingual Emergency Phrase Book
IHCD Training Manual

Signature:

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