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Assessment, Conveyance and Referral of Patients (Emergency Operations)

Document Author: Lead Paramedic for Clinical Development

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1.0	December 2014	Mark Millins	A	Approved by TMG December 2014
1.1	April 2016	Kirsty Lowery-Richardson	D	Ammended and updated for discussion
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2.0	March 2017	Kirsty Lowery-Richardson	A	For final approval - TMG
2.1	May 2018	Risk Team	A	New Visual Identity – Document Formatted
2.2	June 19	Lead Para	A	TMG approved extension until July 2019
A = Approved D = Draft				
Document Author = Lead Paramedic for Clinical Development				
Associated Documentation: Acute Stroke Care Policy Health Record Keeping Standards Guideline Medicines Management Policy Obstetric Care Policy Policy on Paediatric Care Resuscitation Policy Policy for Consent to Examination or Treatment Managing Medical Devices Policy Interfacility Transfer Procedure Pre Alert and Handover Guidance Self Handover Procedure				

Staff Summary

To ensure that all clinicians perform an effective and appropriate clinical assessment of patients
To ensure that staff convey patients, who require it, to a healthcare facility that best meets the patient's clinical needs
To ensure that staff consider a referral to an alternative health care professional, when that is most appropriate for the patient
To ensure that clinicians are empowered to decide when a patient does not need to be conveyed to hospital

1. Introduction

1.1 This policy sets out the procedures that exist to inform staff and is intended to enable and support YAS staff to:

- Perform an effective and appropriate clinical assessment of patients
- Convey patients, who require it, to a healthcare facility that best meets the patient's clinical needs
- Consider a referral to an alternative health care professional when that is most appropriate for the patient.
- Decide when a patient does not need to be conveyed to hospital

2. Purpose/Scope

2.1 This policy is to support the Trust, its staff and the patients that they serve to ensure that appropriate and safe conveyance decisions are made for patients, including those who refuse treatment or are deemed appropriate to refer to an alternative service.

2.2 The policy is informed by current local and national guidelines/policies, this includes UK Ambulance Service Clinical Practice Guidelines 2016.

3. Process

3.1 This policy details procedures to assist decision making around the conveyance and referral of patients.

3.2 Much of the equipment used during patient assessment is single use only and is disposed of following the assessment. Equipment that is not single use is maintained and cleaned under the Decontamination of Medical Devices and Vehicles procedure, and all equipment required is checked under the Managing Medical Devices Policy. Compliance with the checking and cleaning of the equipment is contained with those policy documents.

4. Training Expectations

4.1 All patient facing staff and volunteers working on behalf of YAS should be appropriately trained in the assessment of patients (A to E approach) [Airway to Exposure].

4.2 All YAS clinicians will undertake initial training that includes all elements outlined in Appendix A to P, these principles will be constantly reviewed and refreshed via completion of the Operational Competencies and by participation in Clinical Refresher programmes and Statutory and Mandatory Training scheduled in line with the findings of the Trust's Annual Training Needs Analysis (TNA).

5. Implementation Plan

5.1 This policy will be disseminated to staff using a multi-factorial approach, including reference within all core training delivered in the Trust, the use of YAS 247, Clinical Catch-up and cascade by the Clinical Development Managers and Clinical Supervisors.

5.2 The latest ratified version of this policy will be posted on the Trust's intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during their induction to the Trust.

6. Monitoring Compliance with this Policy

6.1 The Head of Clinical Effectiveness will monitor the application of this policy through regular scheduled audit and will report back to the Clinical Governance Committee. These audits form part of the reporting process for the National Ambulance Quality Indicators, which the Trust is fully compliant with.

7. References

- UK Ambulance Services Clinical Practice Guidelines 2016
- NICE Guidelines [CG160] 2013. Fever in under 5s: assessment and initial management

8. Appendices

- Appendix A – Definitions
- Appendix B – Roles and Responsibilities
  - (i) Consultation and Approval Process
- Appendix C – Patient Assessment
  - (i) Clinical Decisions and Responsibility
- Appendix D – Assessment Tools
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  - (iii)YAS Paediatric Sepsis Screening Tool
  - (iv) Major Trauma Triage Tool
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- Appendix F – Special Patient Groups
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  - (iii) Major Trauma
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- Appendix M – Pre-alert
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- Appendix O – Conveyance Requirements - General
- Appendix P – Advice and guidance for YAS clinicians regarding advice or treatment given to relatives, friends and colleagues

- Appendix Q – Dealing with incidents that have not been allocated via EOC (also see Appendix – P)
- Appendix R – Maintaining communication on scene and during conveyance

Appendix A – Definitions

Glossary of Terms	
ATMIST	Age, Time, Mechanism, Injuries, Signs, Treatments
ED	Emergency Department
GCS	Glasgow Coma Scale
MTCTC	Major Trauma Centre Triage Coordinator
NEWS	National Early Warning Score
PCR	Patient Care Record

Appendix B – Roles and Responsibilities

The Executive Medical Director, supported by the Deputy Medical Director, has overall responsibility for the implementation of this policy.

The Lead Paramedic is responsible for ensuring that the policy complies with the latest clinical guidance from JRCALC Clinical Practice Guidelines, NICE and other relevant sources, and for its dissemination to clinical staff.

The Head of Clinical Effectiveness is responsible for auditing the outcomes of this policy and reporting them to the National Ambulance Service Framework. National Ambulance Non-Conveyance (NANA).

The Head of Education and Standards will produce a training plan for this policy in line with the Trust's Training Needs Analysis.

Clinical Development Managers and Clinical Supervisors will ensure that staff are supported with regard to education and process relating to their role.

Clinical staff will ensure that their practice is in line with this policy.

All A&E operational staff have a responsibility to ensure that they are familiar with and adhere to this policy and clarify any areas of uncertainty with a Clinical Manager, Clinical Development Manager, Clinical Supervisor, Clinical Tutor, Emergency Operations Centre (EOC) Clinical duty Managers, Clinical Advisors or MTCTC.

All A&E operational staff must ensure they are familiar with the local procedures within the area they are working in relation to this policy. In addition they should refer to the current UK Ambulance Services Clinical Guidelines and any other relevant national guidance, e.g. NICE, as applied to YAS approved clinical practice.

(i) Consultation and Approval Process

This policy will be agreed by the YAS Clinical Governance Group which has representatives of all interested parties from within YAS including Staff side representation.

The policy will be approved by the Trust Management Group.

Specific consultation has taken place with the YAS Head of Safeguarding and the YAS Expert Patient.

Appendix C – Patient Assessment

A full clinical assessment should be undertaken on all patients and documented to include:

- Primary survey: Catastrophic Haemorrage check, Airway
- Breathing, Circulation and Disability
- A focussed patient history should be obtained to include presenting complaint, history of presenting complaint, past medical history, drug history and family/social history as required. Where a patient is critically ill or injured the history taking should be adjusted appropriately.
- Appropriate vital signs (as a minimum this must include pulse, respiratory rate and Glasgow Coma Scale , other observations should be made according to the presenting complaint) must be recorded. A National Early Warning Score (NEWS) must be calculated and recorded [see appendix D (i)].
- An appropriate physical examination should be performed maintaining patient dignity at all times.
- Specific tests must only be conducted if they will inform clinical decision making e.g. a 12 lead ECG for a patient who has a traumatic injury is not always necessary

(i) Clinical Decisions and Responsibility

Where the clinician on scene with the patient is unsure of a management plan or wishes to discuss the possibility of increasing a drug dose or administering a drug outwith their guidelines they may seek assistance via the MIC (Medical incident commander – available on the telephone 24/7).

For general guideline or protocol queries whilst formulating a management plan the clinician may speak to a Clinical Advisor in the EOC Clinical Hub.

Where a clinician wishes to discuss a traumatically injured patient, with a view to deciding upon the appropriate desination of the patient they should speak to the MTCTC (Major Trauma Centre Triage Co-ordinator in EOC).

It is important though that clinicians are clear that the responsibility for a patient remains with the senior clinician en-scene, and though guidance may be sought from others the duty of care remains with the individual at the patient's side.

Where clinicians of equal status are in attendance of a patient, the responsibility is shared, regardless of attending/driving status and the care of the patient and duty of care belongs equally to both.

Appendix D – Assessment Tools

Assessment tools have been developed for major trauma, sepsis and feverish children and these tools should be used to aid clinical decision making he outcome of any clinical tool utilised must be recorded on the PRF.

(i) NEWS

Any patient who has a NEWS score of 5 or more MUST be conveyed to hospital unless clinically inappropriate e.g. end of life care:

National Early Warning Score (NEWS)

Physiological Parameters	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Supplemental Oxygen?		Yes		No			
Temperature	≤35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥39.1	
Systolic BP	≤90	91-100	101-110	111-219			≥220
Heart Rate	≤40		41-50	51-90	91-110	111 -130	≥131
Level of Consciousness				A			V, P, or U

The following narrative is supplied to staff with the NEWS table in the YAS Clinical Pocket book:

NEWS will assist in decision-making when faced with a medically unwell patient that potentially requires clinical intervention.

Support Level (ECA, UCSW, AP, EMT-1)

In any circumstances where you feel unsure or unhappy with your ability to manage a patient, call the clinical hub for guidance.

If score 0-4, convey as instructed. If score ≥ 5 or any amber/red criteria, call clinical hub for advice.
Call for clinical back up immediately for any patient in cardiac arrest.

Clinician (Paramedic, AEMT, EMT-2*)

In any circumstances where you feel unsure or unhappy with your ability to manage a patient, call the clinical hub for guidance.

If score 0-4, consider alternatives to ED (Pathfinder).

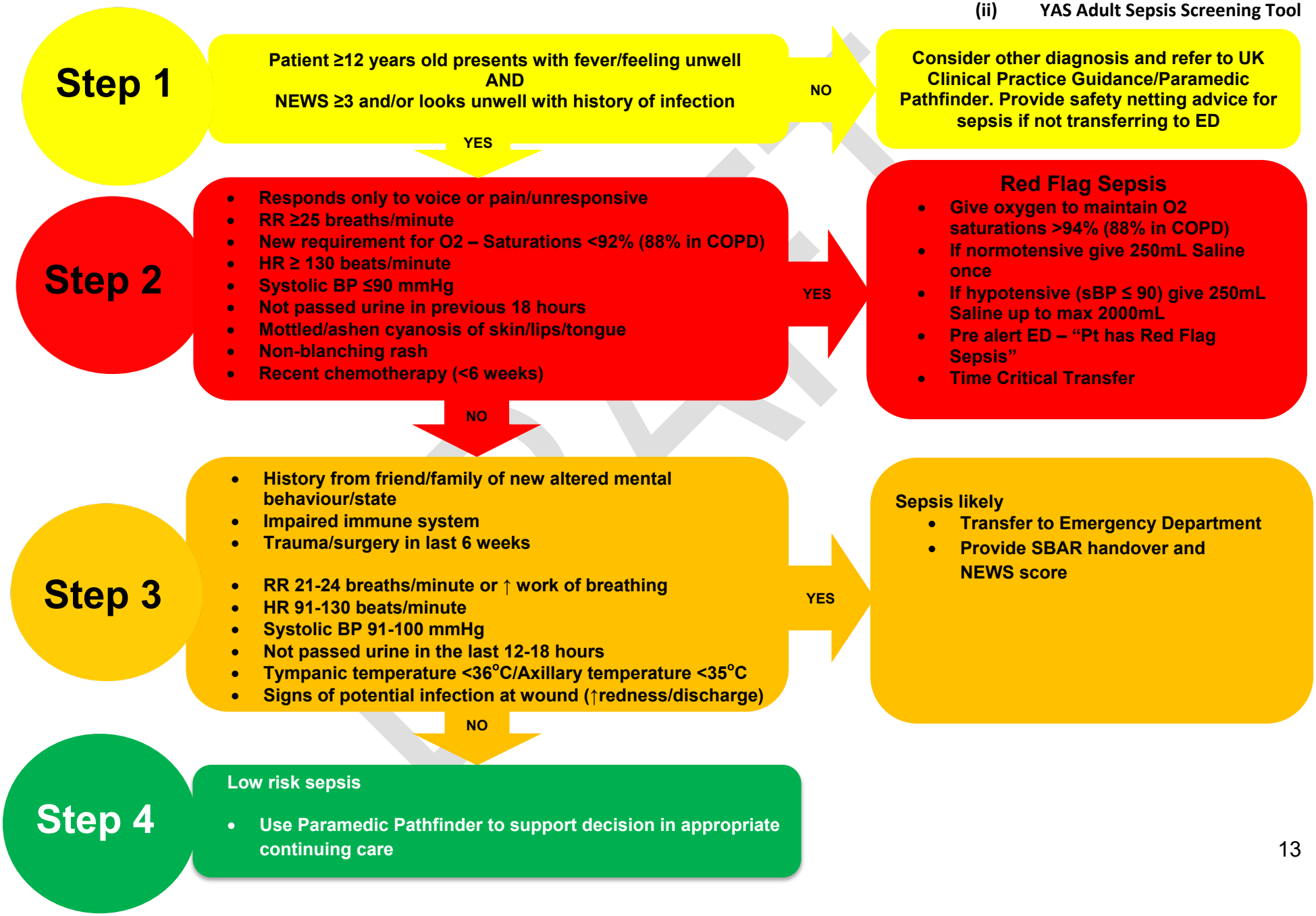
***EMT-2 to seek the authorisation of a senior clinician (EOC Clinical Duty Manager)**

5-6, or any amber, convey to ED or appropriate receiving unit (pPCI, Stroke etc.)
≥7 Pre-alert receiving ED requesting 'resus assessment'.

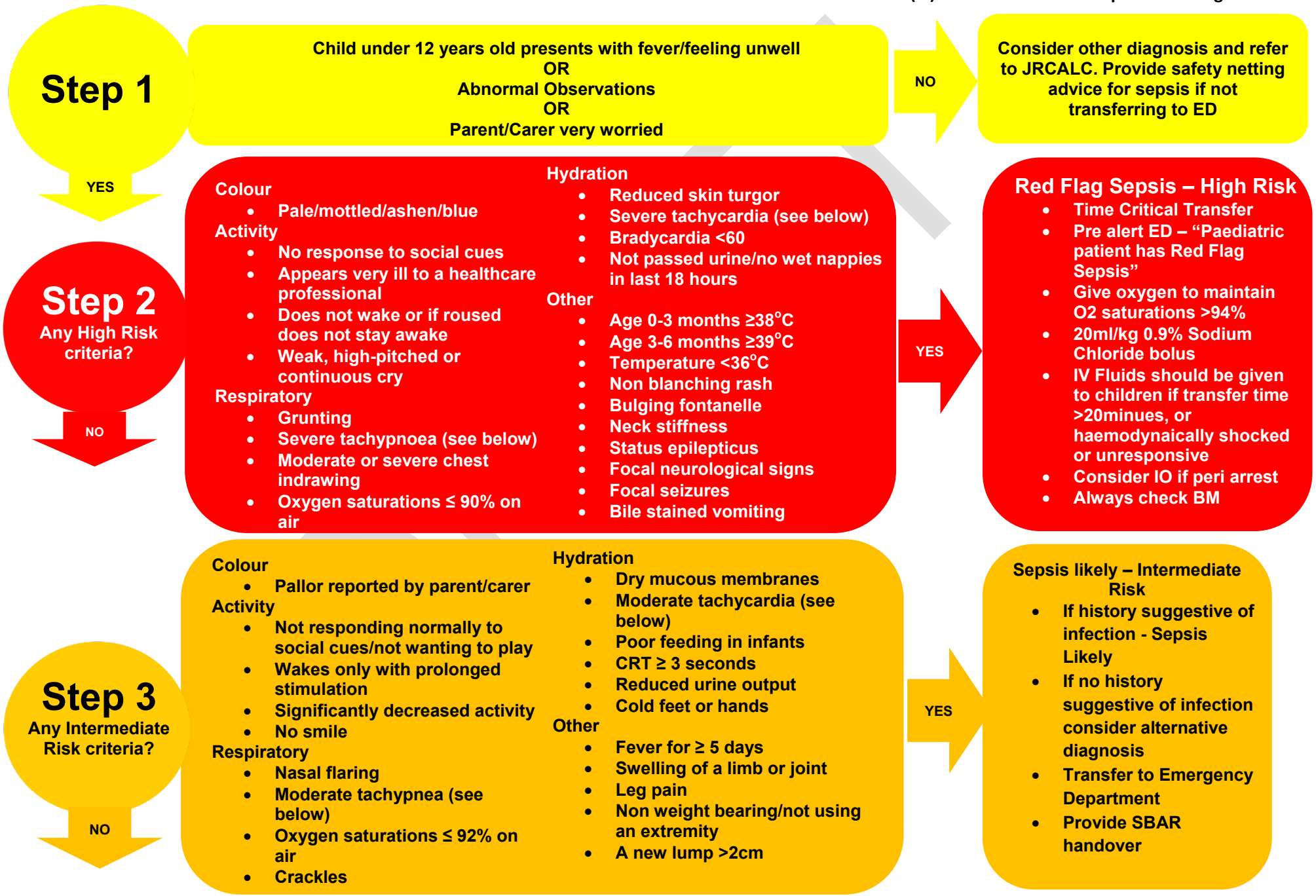
(ii) Sepsis Screening Tool

This tool should be applied to any patient presenting with symptoms that may be allied to sepsis, i.e hx of feverish illness, general infection type symptoms. There are separate tools for adult and paediatric patients (see following pages):

(ii) YAS Adult Sepsis Screening Tool



(iii) YAS Paediatric Sepsis Screening Tool



Step 4
Low Risk

Colour
- Normal colour of skin, lips and tongue

Activity
- Responds normally to social cues
- Content/smiles
- Stays awake or awakens quickly
- Strong normal cry/not crying

Hydration
- Normal skin and eyes
- Moist mucous membranes

Other
- No amber or red symptoms or signs
- child over 2 years old

YES

All under 2 year olds must be transferred to ED

Consider ED where there is any doubt that the child could be seriously ill, regardless of age, or in any circumstances where the social or psychological environment suggests that they may not receive adequate supervision or care

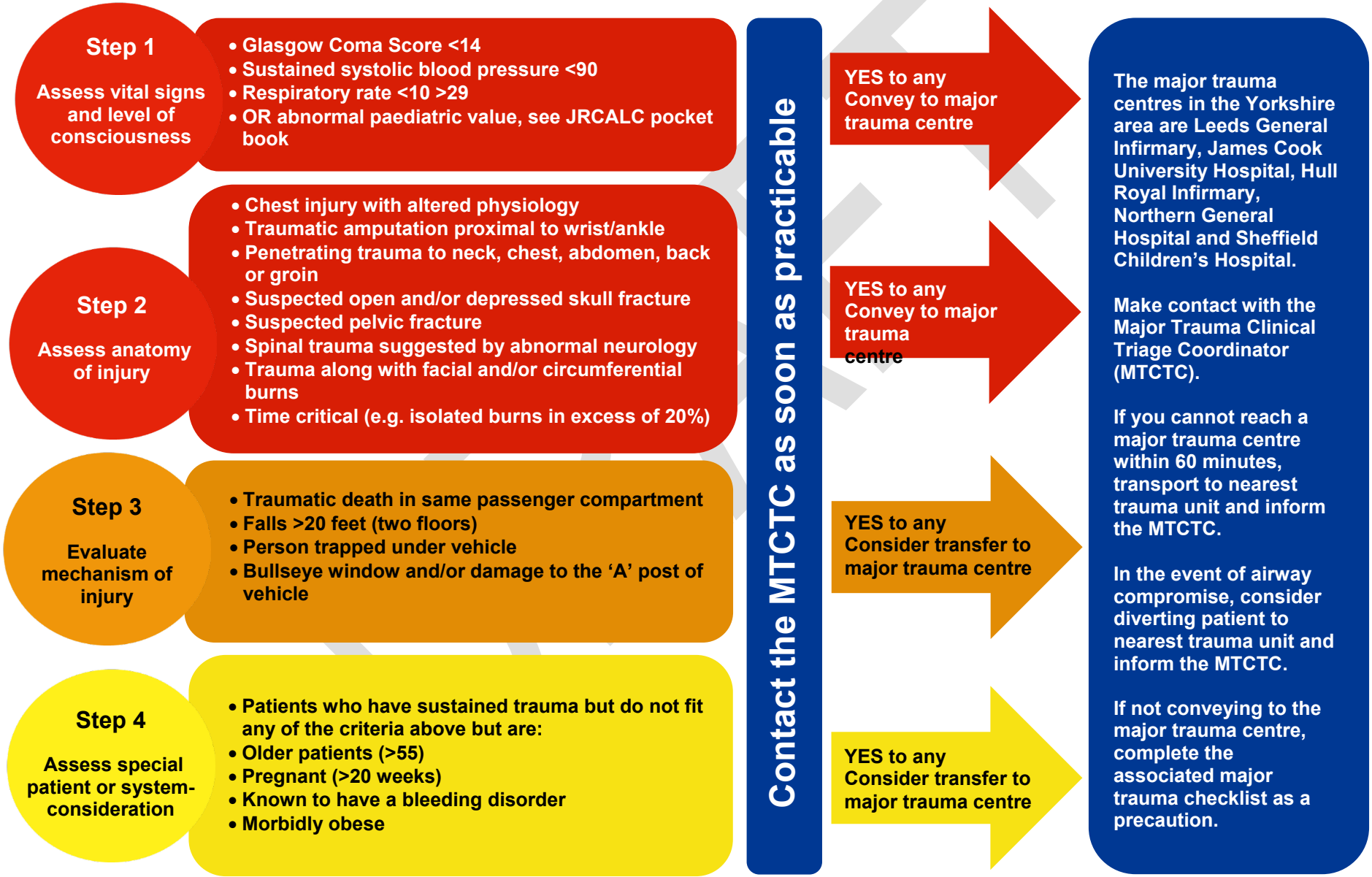
Otherwise consider self-care or referral to primary care (In or Out of Hours GP)

Age	Tachypnea		Tachycardia	
	Moderate	Severe	Moderate	Severe
1 year	50-59	≥60	150-159	≥160
1-2 years	40-49	≥50	140-149	≥150
3-4 years	35-39	≥40	130-139	≥140
5 years	27-28	≥29	120-129	≥130
6-7 years	24-26	≥27	110-119	≥120
8-11 years	22-24	≥25	105-114	≥115

(iv) Major Trauma Triage Tool

Trauma patients should be assessed as per the current UK Ambulance Services clinical Guidelines and must be triaged using the major trauma triage tool. Contact should be made with the major trauma centre triage coordinator as soon as practicable. If a patient triggers step 1 or 2 of the major trauma triage tool and they are within 60 minutes travelling time of a major trauma centre then they should be conveyed there. If the patient has an unmanageable airway and/or any catastrophic haemorrhage then contact should be made with the MTCTC and they should be conveyed to the nearest trauma unit. A patient who triggers step 3 or 4 of the trauma tool should be considered for transfer to a major trauma centre and contact should be made with the MTCTC. A pre-alert using the ATMIST format should be used for any patient who is bypassed to a major trauma centre or is conveyed to a trauma unit due to an unmanageable airway and/or any catastrophic haemorrhage. All major trauma patients should be handed over using the ATMIST format – (see following pages):

Major Trauma Triage Tool



If not conveying to the major trauma centre use this checklist to assist your decision-making. Does the patient fulfil any of the following criteria?		
Sustained respiratory rate <10 or >29	YES	NO
Systolic BP <90mmHg or absent radial pulses	YES	NO
Sustained tachycardia >120 or tourniquet applied	YES	NO
GCS motor score of 4 or less (withdrawal to pain)	YES	NO
Open pneumothorax or flail chest	YES	NO
Crushed, de-gloved or mangled limb	YES	NO
Suspected major pelvic fracture	YES	NO
Neck or back injury with paralysis	YES	NO
Amputated limb proximal to wrist or ankle	YES	NO
Suspected open or depressed skull fracture	YES	NO
If YES to any of the criteria move to Section 2 If NO criteria are met, transport to nearest trauma unit as per normal procedures		

Section 2 Does the patient fulfil the following safety criterion?		
Can the airway and any catastrophic bleeding be controlled?	YES	NO
Can the major trauma centre be reached within 60 minutes of leaving scene?	YES	NO
If YES transport to nearest major trauma centre If NO criteria are met, transport to nearest trauma unit as per normal procedures		

Appendix E – Paramedic Pathfinder

YAS clinicians who have been trained in the use of Paramedic Pathfinder should use this decision support algorithm to assist them in their clinical decision making. Any patient who has a red outcome from Paramedic Pathfinder must be conveyed to the appropriate receiving unit (with the exception of acute mental health and end of life care which should be managed appropriately). Any patient who has an amber outcome from Paramedic Pathfinder may be referred to an appropriate health care professional using a recognised pathway; this may involve transport to an urgent care centre, the patient conveying themselves or the patient being left at scene for a visit by another clinician as clinically appropriate. Any patient who has a blue outcome should only be left at scene (although a referral may still be appropriate) providing they are either able to manage their own self-care or they have an adequate social network to manage them safely. The self-care check list should be completed for these patients and this should be documented on either the Pathfinder record or by using the clinical app (there is no requirement to complete an AS9 patient refusal form if the pathfinder documentation has been completed).

If a referral is not possible for a patient with an amber outcome they should be conveyed to the Emergency Department (ED). If there are concerns for the social care of a patient with a blue outcome they should be either upgraded to an amber outcome and referred to a health care professional or conveyed to the ED if this is not possible, and this must be documented appropriately.

All clinicians who are trained in the use of Paramedic Pathfinder must use either the printed pads or the clinical app to record their clinical decision with each patient. If the patient is in a critical condition then the form or the app can be completed after the patient has been handed over to the receiving hospital team but before they clear with EOC.

(i) Discriminator Codes

Code	Discriminator MEDICAL	Destination
1	Stroke	Pathfinder is N/A to these patient categories. Manage the patient according to JRCALC guidelines and convey to appropriate hospital if required.
2	Non-Traumatic Chest Pain	
3	Patients <12 Years of Age	
4	Obstetric and Gynaecological Presentations	
5	Acute Mental Health Presentations	
6	Overdose with Possible Lethality	
7	End of Life	
8	NEWS Score 5 or greater	
9	Airway Compromise	Nearest Emergency Department
10	Sudden Worsening of Breathing	
11	Shock	
12	Uncontrollable Bleeding	
13	History of New Neurological Deficit	
14	Unable to Walk	
15	Reduced Level of Consciousness	
16	Unmanageable Pain	
17	History of Unconsciousness	
18	Headache as Primary Presentation	
19	Purpura/ Non-Blanching Rash	
20	Vascular Compromise	
21	Tachycardia >120	

Code	Discriminator TRAUMA	Destination
38	Patients <5 Years of Age	Pathfinder is N/A to these patient categories. Convey to nearest ED.
39	NEWS Score 5 or greater	
40	Airway Compromise	Nearest Emergency Department
41	Progressive / Sudden Worsening of Breathing	
42	Shock	
43	Uncontrollable Bleeding	
44	New Neurological Deficit	
45	Acute Loss of Mobility	
46	Reduced Level of Consciousness	
47	Unmanageable Pain	
48	Significant Mechanism of Injury (inc Spinal Immobilisation)	
49	Head injured patient on anti-coagulant therapy or with loss of consciousness/ amnesia in a patient aged over 65	
50	Penetrating Injury of Head, Neck or Torso	
51	Gross Deformity/ Open Fracture	
52	History of Unconsciousness	
53	Vascular Compromise	
54	Critical Skin	
55	Inhalation Injury	
56	Direct Trauma to the Neck or Back	
57	Facial Oedema	

22	Temp ≤ 35 Deg C or ≥ 40 Deg C	
23	Acutely Vomiting Blood	
24	Haematuria/ First Episode Retention	
25	Abdominal Pain Radiating to Back	
26	Significant PR Bleed	
27	Hyperglycaemia > 17 mmol	
28	Temperature > 38.5 Deg C	Walk-in Centre OR Community Service OR GP/AHP OR Community Care Pathway (red discriminators excluded)
29	History of Recently Vomiting Blood	
30	Hyperglycaemia 10-17 mmol (without ketosis)	
31	Retention of Urine	
32	Vertigo	
33	Abnormal Pulse	
34	Facial/ Tongue Oedema	
35	Significant Cardiac History	
36	Requires medical treatment/assessment	
37	Fulfils Criteria for Self Care Pathway (SCP)	Complete self-care checklist

58	Temp ≤ 35 Deg C	
59	Electrical or Chemical Injury	
60	Requires further assessment (red discriminators excluded)	Consider appropriate WIC
61	Fulfils Criteria for Self Care Pathway (SCP)	Complete self-care checklist

Self-Care Checklist General Principles
Ensure the patient does not need medical attention
Ensure the patient is not a vulnerable person
Ensure there are no urgent social concerns
Ensure the patient can feed and hydrate themselves
Ensure the patient is not isolated without social contact
Ensure the patient does not lack mental capacity

Get the APP scan the QR code

(ii) Paramedic Pathfinder Form

Date:	Clinician Name:	Terrafix PIN:	Station:

Incident Number	NEWS Score	Area	Discriminator number	Referral choice (Give surgery name not Drs name if referring to GP)	Successful referral Y/N (and failure code if unsuccessful)	Conveyed Y/N	State hospital/facility conveyed to or service referred to	If self-care confirm self-care checklist completed
1234	2	Leeds	32	Meanwood Surgery	Y	N	n/a	
1235	3	Leeds	36	Hill foot surgery	N3	Y	St James'	
1236	0	Wakefield	37	self-care		N		Y

Referral failure codes 1: Service closed 2: Receiving clinician refused to accept patient 3: Receiving clinician advised ED 4: Service full or no appointments 5: Unable to contact service or waiting too long for call back 6: No x-ray facilities available 7: No emergency care plan for patient 8: Receiving clinician recommends own GP

Appendix F – Special Patient Groups

Patients must be conveyed to the nearest appropriate receiving unit according to their presenting complaint. Any clinical treatment required either prior to or during transport should be in line with current UK Ambulance Services Clinical Practice Guidelines (2016). General conveyance requirements are set out in Appendix M.

(i) Acute Stroke Patients

Stroke services are available across the Yorkshire and Humber region with each acute trust offering thrombolysis services at differing times with a variance on criteria based on location of stroke units and stroke research participation of that trust. Each of the pathways are different and change regularly to reflect the national accelerated stroke programme being implemented across the region. Stroke patients should be conveyed in accordance with the stroke pathway document.

(ii) STEMI

Patients with ST elevation myocardial infarction should be conveyed directly to a specialist cardiac catheter lab for primary percutaneous coronary intervention (pPCI). If a PPCI unit is unable to accept a patient it must be documented on the PCR and the patient should be conveyed to the nearest appropriate ED with a pre-alert call made. STEMI patients should be managed in accordance with the appropriate pathway document.

(iii) Major Trauma (see appendix D (iv))

Trauma patients should be assessed as per the current UK Ambulance Services clinical Guidelines and must be triaged using the major trauma triage tool. Contact should be made with the major trauma centre triage coordinator as soon as practicable. If a patient triggers step 1 or 2 of the major trauma triage tool and they are within 60 minutes travelling time of a major trauma centre then they should be conveyed there. If the patient has an unmanageable airway and/or any catastrophic haemorrhage then contact should be made with the MTCTC and they should be conveyed to the nearest trauma unit. A patient who triggers step 3 or 4 of the trauma tool should be considered for transfer to a major trauma centre and contact should be made with the MTCTC. A pre-alert using the ATMIST format should be used for any patient who is bypassed to a major trauma centre or is conveyed to a trauma unit due to an unmanageable airway and/or any catastrophic haemorrhage. All major trauma patients should be handed over using the ATMIST format.

(iv) Neonatal and Obstetric

The process for the Conveyance of neonatal and obstetric patients between hospitals is documented in the YAS inter-facility transfer policy.

Pre-hospital conveyance of the neonatal and obstetric patients is in line with the YAS procedure for the management of obstetric and gynaecological emergencies:

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Maternity Prehospital Screening & Action Tool

Manage Haemorrhage Immediately

Antepartum Haemorrhage

<20 weeks – consider
- Referred pain to shoulder, Ectopic, Miscarriage
- ?Time critical with pre-alert nearest ED
- IV access en route & oxygen

≥20 weeks – consider
- Constant Abdominal Pain, Back Pain, Placental Abruption, Placenta Praevia
- ?Time critical with pre-alert Nearest Obstetric Unit
- Left lateral positioning
- IV access en route & oxygen

Postpartum Haemorrhage Immediately After Birth

Consider 4 T's Tone, Trauma, Tissue, Thrombin
Uterine muscle tone? Vaginal tear? Retained placenta?
Clotting problems?
Placenta In Situ
- Misoprostol Oral/Rectal (unless contra-indicated)
- Time critical with pre-alert Nearest Obstetric Unit
- IV access en route

Placenta delivered
- Uterine massage & offer Entonox
- Misoprostol Oral/Rectal (unless contra-indicated)
- Time critical with Pre-alert Nearest Obstetric Unit
- IV access en route

Vaginal Trauma
- Apply direct external pressure to tears
- Time critical with Pre-alert Nearest Obstetric Unit
- IV access en route

24 hrs to 12 weeks postnatal
Consider Retained placenta? Sepsis?
- Time critical with Pre-alert Nearest ED
- IV access en route
- Treat RED flag sepsis were appropriate

Primary Maternal Assessment

Assessment			Red Flags- May indicate deterioration
Looks Unwell?		NO	YES
A B	Respiratory Rate SP0²	11 - 20 95% - 100%	0-10 ≥21 ≤94%
C	Pulse Rate	50-99	≤49 ≥100
	Systolic BP	100-149	≤99 ≥150
	Diastolic BP	40-90	≤39 ≥91
D	Neurological Response AVPU	Alert	Nil response to voice, Pain, or Unresponsive Fitting, Twitching, Visual Disturbance >20 wks position left lateral tilt OR manual uterine displacement
E	Temp	36 – 37.9	≤35.9 ≥38
	Bleeding	No, Spotting	YES - > 50mls Soaked sanitary towel, Blood on the floor
	Membranes fluid	Intact, clear ≥37 weeks	<37 wks blood stained, meconium, offensive
F	Uterine Fundus	Soft Contractions ≥37 weeks in labour	Contraction <37 wks, constant pain, tender, woody
	Foetus	Document last reported movements	
G	Load and Go	<20 weeks or ≥20 weeks- consider plan	Early extrication and Interventions enroute

Consider appropriate pain relief

KD Sept 16

Maternity RED Flags? Convey immediately with any 1 red flag

<20 weeks Pre alert nearest ED
≥20 weeks Pre-alert nearest obstetric unit
-Consider maternal position
YES

Cord prolapse, Breech, Shoulder Dystocia
Pre – alert nearest Obstetric Unit
Consider IV Access en route
-Consider Patient Position

NO <20 weeks ED
≥20 weeks RING maternity booked unit
≥37 weeks in Labour–nearest maternity unit

Use SBAR Tool to Handover in Hospital

S **Situation**
State your name & role
Describe your concern & the red flag

B **Background**
State the reason for the admission
Summarise the relevant history
State the risk of the woman

A **Assessment**
Report the results of the A-F assessment, what interventions you have done, state what you think is happening

R **Recommendation**
Explain what you need and be specific

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Maternity Prehospital Screening & Action Tool

YAS Maternity Care Pathway – Yorkshire and the Humber

When a midwife is on scene they will assume primacy and crews should work under their clinical direction and may be asked to assist with clinical procedures.

If a midwife is not on scene do not delay patient transport unless birth is in progress.

JRCALC and YAS Obstetric Care Policy when caring for mother and baby pre and post-delivery.

Mother in Labour but not delivered and >20 weeks	Load and Go
Complicated **Mother presenting with the following – eclampsia, PV bleed, cord prolapse, severe continuous abdominal pain or presentation of a part other than the head, buttocks, or feet (one foot/hand/arm)**	**Load and Go**
Birth Imminent **Unless head, buttocks, feet are presented and you establish delivery is progressing, then manage the delivery.** **If birth does not progress**	**Load and Go** **Load and Go**

Load and Go
Do NOT delay!
Transport to nearest obstetric unit. If the mother is in cardiac arrest, transport to nearest ED (if obstetric unit not on the same site, request obstetrician to nearest ED).
Provide a structured handover and pre-alert: SBAR including ETA

For Early Pregnancy Units contact clinical hub 0300 330 0274

Mother in Labour <20 weeks

Transport to ED

Or **where there is a local Early Pregnancy Unit (EPU) pathway in place, follow local pathway.**

Always transport in cases where the mother has delivered the foetus

Baby Born on your arrival;
Both mother and baby will need to be transported unless the midwife has arrived. If not, pre-alert the maternity suite and take advice. Then transfer as the clinical condition indicates.

Pregnant women (>20weeks) presenting with non-obstetric conditions should be discussed with the Maternity Unit for direct transfer to the Maternity Unit. Does not include trauma (unless no injury), airway compromise, Cardiac or time critical cardio-respiratory conditions.

KD Sept 16

Maternity Numbers

South Yorkshire
Jessop, Sheffield 0114 226 8398/8223
Chesterfield 01246 512499
Bassetlaw 01909 502232
Barnsley 01226 431870/1871
Doncaster 01302 642644
Rotherham 01709 424491

East Yorkshire
Hull Royal Infirmary 01482 604433
Scunthorpe 01472 875852

West Yorkshire
Airedale 01535 292402
Dewsbury 01924 816161
Pinderfields 01924 541662
LGI 0113 392 7445
Bradford 01274 364514
St James's 0113 206 9103
Calderdale 01422 222111

North Yorkshire
York 01904 726004
Scarborough 01723 342124
Harrogate 01423 553184
James Cook 01642 854833/4881

(v) Critical Care

Conveyance of critical patients between hospitals is documented in the YAS inter-facility transfer procedure.

(vi) Thermal injuries

Conveyance of patients with isolated burns is to the nearest trauma unit. A secondary transfer may be requested following assessment of the patient in the receiving department.

(vii) Vascular Services

Vascular services have been reconfigured in some areas. This has resulted in the need for specific local procedures on where best to convey acute vascular patients to meet their level of clinical need. All new local procedures are approved by the Clinical Governance Group and are then cascaded via the clinical app, Operational Update Bulletins, YAS intranet and supported by local clinical teams and the clinical hub.

Appendix G – Children

The Royal College of Paediatrics and Child Health recommend that all children under the age of 2 must be conveyed to an appropriate health care facility following a 999 call to the ambulance service. For that reason within YAS all children under the age of two years must be conveyed to a health care facility. If the parent or carer refuses transport of the child then referral to an appropriate health care professional must be made (for example referral to a GP or health visitor).

Children from the age of 2 to 12 who present with a feverish illness should be assessed using the paediatric triage tool and other medical conditions should be assessed using the current UK Ambulance Services Clinical Practice Guidelines. Children presenting with traumatic injuries must be assessed using the current UK Ambulance Services Clinical Practice Guidelines and the major trauma triage tool must be used to determine the appropriate destination. If a child requires transport to hospital they must be conveyed to a facility that has the capability to assess paediatrics. If the origin of a call to a child aged under 2 is from the 111 service then the child may be referred to another healthcare professional if they do not require transport to the ED.

Note that Paramedic Pathfinder cannot be used in medical cases for children under the age of 12 and in traumatic cases for children under the age of 5.

The threshold for conveying children to hospital is very low and unless the senior clinician on scene is absolutely certain that a child is either not injured or that they do not have any red or amber triggers on the paediatric triage tool then they should be conveyed to an appropriate ED or referred to a health professional e.g. a GP who accepts the duty of care from the point of referral. Where a child over the age of 2 does not need any form a medical treatment this must be documented and the child must be left in the care of an adult. Children who are not conveyed should be safety netted ensuring that parents and carers are advised to seek further advice if: The child has a fit, develops a non-blanching rash, they feel that the child's health is getting worse, they are more worried than when they last received advice, any fever lasts longer than 5 days or they are distressed or concerned that they are unable to look after their child. Consideration that the child may be vulnerable or that there is the possibility of child abuse should be always taken into account before a decision is made. In cases of paediatric overdose and poisoning the current UK Ambulance Services Clinical Practice Guidelines recommend automatic conveyance to hospital.

There may be occasions where the child or parent/carer does not wish the child to travel despite a recommendation to do so by the attending staff. There may also be occasions where there is refusal to travel by the child or the parent/carer. For any child that refuses treatment and transport the ambulance clinician MUST make an immediate referral to another healthcare professional who can assume responsibility for their on-going care. In any case of refusal, full documentation should be completed to this effect.

If a child under the age of 16 refuses life sustaining treatment then reference should be made to the policy for consent to examination and treatment which offered the following options:

Accept refusal
For example if a child refuses to be cannulated in order to receive morphine. The refusal can be accepted and pain controlled with Entonox

Persuade
A child may be frightened or anxious about attending hospital and in a non-life threatening situation the attending clinician can attempt to persuade the child to attend

Treat on the basis of parental consent
Where a child refuses what is considered life sustaining treatment the child can be treated with parental consent. If the parents are absent the clinician can act in the child's best interests. Occasionally a child under the age of 16 may physically refuse to be conveyed and in these situations assistance should be sought from the police.

Children in cardiac arrest must always be conveyed to hospital with full resuscitation in progress unless the Police request that the body remains on scene. However, if there is unequivocal evidence that the child has died and is clearly beyond medical help then the child should be conveyed to an appropriate ED without resuscitation in progress (refer to Resuscitation Policy for further information).

(i) Paediatric Triage Tool

Step 1

- **Colour:**
  - Pale/mottled/ashen/blue
- **Activity:**
  - No response to social cues
  - Appears ill to a healthcare professional
  - Unable to rouse, or if roused, does not stay awake.
  - Weak/high pitched/continuous cry
- **Respiratory**
  - Grunting
  - Tachypnoea: RR >60/min
  - Moderate or severe chest indrawing
- **Hydration:**
  - Reduced skin turgor
- **Other:**
  - 0-3 months, temp ≥38°C
  - 3–6 months, temp ≥39°C
  - Non blanching rash
  - Bulging fontanelle
  - Neck stiffness
  - Status epilepticus
  - Focal seizures
  - Focal neurological signs
  - Bile-stained vomting

If YES to ANY commence TIME CRITICAL TRANSFER to nearest appropriate ED

Step 2

- **Colour:**
  - Pallor reported by parent/carer
- **Activity:**
  - Not responding normally to social cues
  - Wakes only with prolonged stimulation
  - Decreased activity
  - No smile
- **Respiratory**
  - Nasal flaring
  - Tachypnoea:
  - ● RR >50/min age 6–12 months
  - ● RR >40/min age >12 months
  - O2 sat ≤ 95% in air
  - Crackles
- **Hydration:**
  - Dry mucous membranes
  - Poor feeding in infants
  - Capillary Refill Time (CRT) ≥3 seconds
  - ↓Urinary output
- **Other:**
  - Fever for ≥5 days
  - Swelling of a limb or joint
  - Non-weight bearing/not using an extremity
  - A new lump >2 cm
  - Immunosuppressant drugs (e.g. steroids)
  - Child under 2 years of age

Step 3

- **Colour:**
  - Normal colour of skin, lips and tongue
- **Activity:**
  - Responds normally to social cues
  - Content/smiles
  - Stays awake or awakens quickly
  - Strong/normal cry/not crying
- **Respiratory**
  - Normal rate for age
- **Hydration:**
  - Normal skin and eyes
  - Moist mucous membranes
- **Other:**
  - No amber or red symptoms or signs and child over 2 years of age

If YES to all safety net the child as detailed below. Consider ED where there is any doubt that the child could be seriously ill, regardless of age, or in any circumstances where the social or psychological environment suggests that they may not receive adequate supervision or care if left at home.

Safety netting for step 3 outcome only
Advise parents and carers:
Of the antipyretic interventions available, to offer their child regular fluids (if breastfeeding then continue as normal).
To look for signs of dehydration (sunken fontanelle, dry mouth, sunken eyes, absence of tears, poor overall appearance).
To encourage their child to drink more fluids and consider seeking further advice if they see signs of dehydration
How to identify a non-blanching rash
To check their child during the night
To keep their child away from nursery/school while the fever persists and to notify the nursery/school of the illness.

Advise parents and carers to seek further advice if:
The child has a fit
The child develops a non-blanching rash
They feel that the child's health is getting worse
They are more worried than when they last received advice

Appendix H – Conveyance by Rapid Response Vehicle

For many patients the most appropriate form of transport will be by conventional ambulance. However, there may be occasions when it is both safe and clinically appropriate to transport a patient in a rapid response vehicle (RRV). The final decision as whether to transport by RRV rests with the clinician driving the RRV but the following guidance is offered to support that decision making.

A patient considered suitable for conveyance by RRV should have a NEWS score of 4 or less and a Glasgow Coma Scale of 15. They must be mobile and should be able walk to the RRV without deterioration and should be able to gain access and egress from the RRV with minimal assistance. Any body fluids must be able to be contained and no invasive therapy should be initiated either before or during transport by an RRV. The following table acts as a guide but is not an exhaustive list.

Examples of Mobile patients suitable for transfer by RRV vehicle following assessment	**Examples of Patients not suitable for transfer by response vehicle following assessment**
▪ Minor cuts/lacerations requiring closure ▪ Sprains and strains where patient can mobilise safely to the vehicle ▪ Minor stable upper limb fractures where pain controlled. ▪ Small scalp wounds with minor mechanism of injury and GCS 15 throughout ▪ Eye problems ▪ ENT problems ▪ Minor Epistaxis (haemorrhage controlled) ▪ Transfer to walk in centre/GP/alternative care pathway where patient has been accepted by a HCP, but unable to make own way (these patients will be an amber outcome on Paramedic Pathfinder) ▪ Transfer home where the patient fulfils the self-care criteria in pathfinder and the journey time is less than 5 minutes	▪ Chest pain of cardiac origin ▪ Abdominal pain with guarding and tenderness ▪ Head injury with history of unconsciousness ▪ Collapse with history of unconsciousness ▪ Unstable diabetic ▪ Unstable epileptic ▪ Any patient with reduced GCS <15 ▪ Mental health patients ▪ Anyone under the influence of Drugs or significant Alcohol consumption ▪ Unstable COPD/Asthma patients ▪ Any patient with a history of violence ▪ Patients that pose an IPC risk to the vehicle (incontinence etc.) ▪ Patients who have been the subject of an alleged sexual assault

There may be very rare occasions where the risk of transporting a patient in an RRV is lower than the risk of waiting at scene for additional resources. If the decision is taken to convey the patient in an RRV due to unavailability of alternative conveying resources the clinician must document their rationale for this decision.

When a clinician conveys a patient by RRV they should consider the chaperoning advice in Appendix J.

Appendix I – Back up Guidelines for RRV Clinicians

There have been a significant number of instances where RRV clinicians have been on scene waiting for backup with patients who are critically ill. In order to assist staff and to provide timely backup to the most serious clinical cases the following guidance has been developed by the clinical directorate. An RRV clinician who is on scene can request backup as P1 for the most critical patients, P2 for those patients who require a blue light response but are not immediately life threatening and P3 for all other patients. The criteria for these categories are set out below along with some examples as well as the divert criteria for each category.
The effectiveness of this new guidance will be monitored over the next 2 to 3 weeks and it is hoped that further guidance around P3 patients can be developed in the New Year.

The guidance for EMT I EMT II or ECA staff on DCAs who request back up has not changed will continue to operate as normal.
If you have any questions on the backup guidance please contact the clinical directorate or your clinical supervisor.

Back Up Priority	Description	Divert Criteria
P1	**Patient is considered time critical** or requires time critical hospital intervention (e.g. PCI or stroke thrombolysis) and requires immediate additional resources responding as an emergency using blue lights and sirens. Examples; ▪ respiratory/cardiac arrest ▪ any indication of life-threatening asthmatic ▪ uncontrollable haemorrhage ▪ PPCI ▪ Stroke (Pre Alert criteria) ▪ NEWS ≥7 or a time critical red criteria on paramedic pathfinder **Clinician on scene** to request P1 backup and to remain with patient providing clinical care as indicated. P1 backup request to be recorded on the patient record. This category must only be used where clinically indicated.	Dispatcher **must not** divert back-up to another call regardless of priority except Cardiac Arrests
P2	**Patient is not immediately life-threatening**, but requires additional resources responding as an emergency using blue lights and sirens. Example; ▪ Shortness of breath	Dispatcher may divert back-up to RED incidents and P1 back up requests

	▪ NEWS ≥5 or red criteria on paramedic pathfinder Clinician on scene to request P2 backup and to remain with patient providing clinical care as indicated. P2 backup request to be recorded on the patient record.	
P3	**A DCA is required to convey the patient to hospital.** Example: Simple non compounded fracture where pain is controlled without the need for opiates and requires admission or assessment where there is no other method of attending hospital. Also patients who would be able to travel by car, but cannot do so due to reduced mobility. Clinician on scene to request P3 backup and backup request to be recorded on the patient record.	Dispatcher may divert back-up to RED or GREEN 1 & 2 incidents, P1 or P2 back up requests or any G3/G4 incident with a lower response time

Appendix J – Chaperoning

The apparent intimate nature of many clinical activities, if not practiced in a sensitive and respectful manner, can lead to misinterpretation and, occasionally, allegations of abuse. Not understanding the cultural background of a patient can lead to confusion and misunderstanding, with some patients believing that they have been the subject of abuse. It is important that health care professionals are sensitive to these issues and alert to the potential for patients to be the victims of abuse.

Good practice

All staff must follow the following principles of good practice:

- All patients, regardless of age, gender, ethnic background, culture, sexual orientation, disability or mental health status have the right to have their privacy and dignity respected.
- Patients should be offered a chaperone or be invited to have a relative or friend present with them during any examination or procedure. Their personal preference should be documented in their clinical record.
- In order for patients to exercise their right to request the presence of a chaperone, a full explanation of the examination, procedure or treatment to be carried out should be given to the patient, followed by a check to ensure that the patient has understood the information.
- If the patient prefers to undergo an examination/procedure without the presence of a chaperone, this should be respected and their decision documented in the clinical record.
- The patient should be informed if a chaperone is unavailable (either due to unforeseen circumstances or an emergency situation) and they should be asked if they consent to the examination/procedure going ahead without a chaperone or would they prefer to postpone until one is available.
- Patients should be encouraged to maintain independence and self-care as far as is practicable, for example, undressing themselves.
- A culture of openness between patients and health care professionals should be actively encouraged.

Appendix K – Patient Belongings and Medication

Belongings of patients (including) remain their own responsibility unless Mental Capacity is deemed to be lacking. In these circumstances responsibility may lie with a travelling chaperone or where they are travelling alone the responsibility lies with the crew/attending clinician.

Where the crew have taken responsibility of belongings this should be documented and clearly passed to the receiving health care professional on handover.

Appendix L – Documentation

All conveyances and non-conveyances of patients should be recorded on the patient care record (PCR, electronic or paper) and completed in line with local training and PCR completion guidance which is available on the YAS Intranet. If the clinician has been trained in Paramedic Pathfinder then the outcome of each patient contact should be recorded on either the pathfinder form or by the clinical app.

The PCR should accompany the patient and be passed to the receiving clinician as part of the handover of care. When conveying a patient between healthcare facilities, all relevant documentation e.g. clinical records and x-rays, should be transported with the patient and passed to the receiving clinician as part of the handover of care.

Any deviation from the designated destination should be recorded on the PCR.

Documentation should always be comprehensive as per YAS PCR completion guidance and include:

- Details of all clinical assessment, examination and history taking, including pertinent positives and negatives that affected the management of the patient.
- Completion of the pathfinder documentation for those clinicians trained in its use.
- For all non-conveyances the pathfinder documentation or app should be completed or for those staff not trained in its use the Non-Transport and Referral form should be completed but there is no need to complete both.
- Documentation of giving patient/carer a copy of an appropriate YAS patient information leaflet if appropriate
- Document conversations and agreements if a referral is made including name of person who has agreed to accept referral for the patient
- Document response time of other professionals if referred and not conveyed
- Document any refusal to referral; see previous section for further detail.

Those staff trained in Paramedic Pathfinder should complete the pathfinder documentation for each patient either electronically or on paper.

It is important to remember that if there is a need for conveyance to receive medical treatment but a patient does not wish to be conveyed then the patient/carer should complete the refusal section of the non-transport form. The refusal form can only be used if the patient has full mental capacity and is making an informed decision not to attend hospital despite advice to do so.

Medical patients hould be handed over using the SBAR (situation, background, assessment and recommendation) format and trauma patients should be handed over using the ATMIST (age, time, mechanism, injuries, signs and symptoms and treatment/immediate needs).

Appendix M - Pre-alert

Pre-Alerts must be made to a clinician in the receiving hospital by the attending YAS clinician transporting the patient to hospital, the criteria for pre-alerts are listed below:

- Major Trauma Tool positive
- STEMI
- FAST positive
- Cardiac/Respiratory Arrest
- Airway compromise including Stridor
- Status Epilepticus – Still fitting
- NEWS 7 or more, or any RED criteria
- Red Flag Sepsis

- #NOF – Named hospitals only – Hull, Leeds and Doncaster
- IPC Concerns – Category 3 & 4 only
- More than 2 trolley patients coming from an incident
- Clinician concern/Any specific information needed to be handed over pre arrival e.g. patient violent with police

Early alerts may be made by the MTCTC in the case of major trauma but do not replace the Pre-Alert. A pre alert must be made when 10 minutes from the receiving hospital to enable mobilisation of the appropriate trauma team to receive the patient – this must be made by the transporting clinician directly to the receiving hospital (MTC/TU) [This is the same for both primary and secondary transfers]
Pre Alerts must be made using ATMIST for Trauma patients, and SBAR for Medical and Surgical patients, and include NEWS score.

Appendix N - Handover

A clinical handover should be given to the receiving member of staff followed by a completed patient report form including all relevant clinical and assessment information. YAS staff must ensure that a signature is obtained on the PCR from the healthcare professional taking the handover. An exception to verbal handover would be a locally agreed self-handover procedure.

The patients privacy and dignity must be maintained at all times. Ideally the handover should not take place in a public area.

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 before potentially returning the patient to the hospital. The department the patient was collected from should be contacted for appropriate arrangements to be made for the patient, with the responsibility for the patient resting with the facility that the patient came from. A patient must not be left by YAS staff in a potentially unsafe situation.

Non Resus medical patients should be handed over using the SBAR (situation, background, assessment and recommendation) format and trauma patients should be handed over using the ATMIST (age, time, mechanism, injuries, signs and symptoms and treatment/immediate needs). This must include the initial NEWS score and any changes.

Resus patient handovers should be undertaken by the YAS lead clinician following transfer of the patient to the resus bed (unless directed otherwise by the resus team leader). The handover should occur following the team leader identifying themselves, in the following moment of silence. The Paramedic provides a concise and lout ATMIST or SBAR handover <60s.

Self Handover

Patients identified as appropriate for self-handover should be processed as per the Self-Handover Procedure.

Self Handover Guideline V3.pdf

Appendix O - Conveyance Requirements – General

Patient Destination

The destination of the patient must be determined based upon clinical need. The senior clinician must make a full assessment of the patient before determining where the patient will be taken. Guidance on the decision of destination will be from the Paramedic Pathfinder algorithm (if the clinician has undertaken the training) and the current UK Ambulance Services Clinical Practice Guidelines. Staff should consider the clinical needs of the patient, the facilities available at local hospitals and the local pathway/bypass agreements of destination hospital. Where a designated destination has been provided, the patient should 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 may be revised in the best interests of the patient.

A 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 Department. Staff should comply with the request, if the facility has accepted the patient (informing the Emergency Operations Centre before leaving the scene, and recording the name and contact details of the doctor/HCP on the PRF).

Palliative care patients may have a designated destination, as part of an end of life care plan, such as a hospice. This should be taken into account and contact made with the hospice or palliative care team and the appropriate destination appropriate destination should be discussed with the palliative care team.

Removal From Scene

Patients must be removed from scene to the ambulance using the safest method and most expedient route available based upon their clinical needs and their environment.

Staff must ensure that all efforts are made to protect the privacy, confidentiality and dignity of their patients at all times.

Staff must determine the most appropriate method of supporting patients to move and mobilise based upon their clinical assessment, and the availability of additional assistance and/or equipment.

In order to maintain patient’s independence, dignity and respect; every attempt must be made to take mobility aids with the patient as long as the aids can be safely stowed/secured and the patient’s condition is not life threatening.

Should a patient be reluctant or unwilling to allow staff to comply with the moving and handling method deemed appropriate that is relevant in their case, staff should attempt to agree an alternative method but ultimately make it clear to the patient that staff safety cannot be compromised.

Should a patient continue to act against the advice given, EOC should be informed at the earliest convenient opportunity, and the detail recorded on the PRF.

Staff should undertake a risk assessment of the situation in which they find their patient. If they estimate any factors to be beyond their capabilities then assistance of a second ambulance or other services should be sought.

Walking patients should be encouraged to use handrails to assist them. Staff will need to give additional support and exercise extra caution if the person is injured, mobility impaired, has sensory impairment, mental capacity support needs or other relevant condition requiring support.

Staff can request assistance from responsible personnel such as police officers, nursing, portering staff and members of the public but they must be given clear, concise instructions and not asked to undertake any activity that is obviously beyond their capability or which they are reluctant to do.

Staff should use, where appropriate and where training has been undertaken, all available moving and handling aids supplied by the service. If other equipment is available, for example hoists, consideration should be given to allowing only the persons trained in use of the equipment to assist in the handling and moving.

The walking of patients to the ambulance should only be undertaken following a risk assessment by the clinician as to the safest method of transfer and in full agreement with the patient/carer. The rationale for walking a patient to the vehicle must be documented on the PRF.

Escorts

The decision as to whether/how many friends/relatives travel with the patient rests with the ambulance clinicians, and must be based upon both the patient's needs and the practicalities of the patient's treatment. Staff safety is paramount and escorts who appear drunk/disorderly may compromise that safety. Equally refusing an escort may aggravate a situation and will require careful judgement by staff. If a decision is made not to allow escorts, this message should be conveyed with sensitivity, tact and diplomacy. In all cases the vehicle's maximum loading capacity must be observed. All such decisions should be documented on the PRF.

Where the escort/carer has mobility and/or sensory impairment or mental capacity support needs; every effort should be made to transport them with the patient where this can be done safely and the patient's condition is not life threatening.

Patients with dementia or learning disabilities should always be escorted by relatives, carers, or advocates where possible.

Where possible, patients below the age of 18 should be accompanied by a parent or guardian. When this is not possible, 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 may be left unsupervised. However, ambulance staff must convey the child/children or contact EOC/PTS control to arrange for the police to attend and assume responsibility (refer to the YAS Policy for Safeguarding of Children and Young People).

YAS staff must always document the name and relationship of any adults caring for children and young people during contacts.

When YAS staff are conveying children in cardiac arrest to the ED, a parent or carer should always accompany the child where it is appropriate to do so. This is essential for the continuity of information sharing processes.

In order to give maximum protection to patient and escorts whilst on ambulance 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 any 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 an ambulance (where it is possible to do so) rests with the driver.

Wherever possible and where deemed appropriate assistance dogs should be conveyed with the patient.

En Route

Should a patient refuse to wear a seat belt then this must be documented on the YAS Non-transport Referral and Refusal Form and a signature obtained. In the event that a patient is in the care of the service and is deemed critically ill it is expected that the member of YAS staff who is most appropriately trained to deliver extended skills (invasive techniques) will travel with the patient on the journey to hospital. 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.

Should an escort refuse to wear a seat belt then they should not be allowed to travel.

If a patient recovers en-route to a hospital and becomes adamant 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 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. An assessment of the patient's mental capacity should be undertaken. The crew should remain with the patient until the police arrive and on hand-over give the completed copy of the PCR to the receiving officer. If there is a competent person accompanying the patient, that person should be given a copy of the PCR 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.

Upon Arrival

Upon arrival at the destination the patient should be removed from the ambulance using the safest and most appropriate means for their clinical condition.

Appendix P – Advice and guidance for YAS clinicians regarding advice or treatment given to relatives, friends and colleagues

YAS clinicians (especially extended role practitioners) will often be approached by Relatives, Friends, and Colleagues for their advice regarding medical problems they have.

As for any other Healthcare professional caution should be exercised in the advice given.

YAS clinicians **should not:**

- Provide advice or treatment to any family members, especially where doing so might prevent them from seeing their own GP who provides their ongoing medical care. With the exception of acute, unscheduled, or emergency care where failure to offer advice or treatment might be detrimental to the health or recovery of the individual, in which event all further care should be referred to the GP or most appropriate healthcare professional.

- Provide advice on any subject which is outside their competence and training. As per the HCPC you have a duty to refer the individual on to a professional who can address the issue for them.

- Treat Colleagues except where they have presented through the normal channels for the service, for example a 999 call.

- Provide advice or treatment for colleagues on any condition which might have an occupational element e.g. low back pain in Emergency Medical Dispatchers. Individuals who fall into this group should be advised to contact Occupational Health.

- Provide a diagnostic service for a relative, friend or colleague., except where they have accessed the service through the normal channels for the service, where they should appropriately see their GP or self refer e.g. urinalysis or direct x-ray referral.

Every job done by a YAS Clinician whilst employed by YAS and using YAS equipment or treatments needs to be raised as a job on the CAD to ensure that there is a clear audit trail. Failure to do so puts the individual at risk in the event of an adverse incident.

Appendix Q – Dealing with incidents that have not been allocated via EOC (also see Appendix – P)

It is not uncommon for a YAS clinician or crew to be summoned via means outwith the norm, so that the detail is not passed via EOC. This may include (list not exhaustive):

- Being ‘flagged down’ whilst driving
- Being approached whilst parked on standby
- Being approached whilst at an ambulance station/hospital

In this situation, the priority of the clinician is to ensure the safety and well-being of any service user already in their care. This may be delegated to one crew member or another Health Care Professional whilst another investigates the new situation.
EOC should be informed ASAP via a radio message. If the clinician/crew are en-route to an emergency they should assess the needs of the new situation and update EOC so that a decision can be made regarding priority of incidents (the original detail or the new incident).
If the clinician/crew are rapidly transporting a critically injured/ill patient then the individual that has made them aware of the new incident should be made aware that the crew will continue on their journey but that assistance is being sought via normal process.
Where the clinician/crew are available to deal with the incident, this should be communicated with EOC and an incident created on CAD.

Appendix R – Maintaining communication on scene and during conveyance

There are occasions where a crew may become separated on scene. This should be dynically risk assessed and communicated to EOC, making clear which crew member is where, similar communication should ensure that EOC are aware who is travelling in which vehicle where YAS clinicians travel in vehicles that are not those belonging to the trust.