NHS
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# Assessment, Conveyance and Referral of Patients (Emergency Operations)

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**Staff Summary**

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| 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 |

## 1.0 Introduction

1.1 This policy is intended to enable and support YAS staff to work to the expected clinical standards and within their scope of practice in order to:

- Perform an effective clinical assessment of patients to determine a working impression of their presenting complaint
- To determine if a patient needs to be conveyed to a healthcare facility that best meets the patient's clinical needs
- Consider a referral to an alternative health care professional or service when that is clinically appropriate for the patient

## 2.0 Purpose/Scope

2.1 This policy is to support the Trust, its staff, and patients to ensure that appropriate and safe conveyance decisions are made following an attendance by YAS clinicians, including those patients who are deemed appropriate to refer to an alternative service or those who may refuse treatment.

2.2 This policy is informed by current local and national guidelines/policies; this includes the current JRCALC UK Ambulance Service Clinical Practice Guidelines (JRCLAC) and the YAS guidance on a structured approach to clinical assessment.

## 3.0 Process

### 3.1 Introduction

3.1.1 This policy should be read in conjunction with the policy on Patient Consent to Examination or Treatment so that mental capacity can be determined, and consent obtained.

3.1.2 Patients must always provide informed consent prior to any assessment or treatment. All patients are assumed to have capacity to consent unless it is found on balance of probabilities that they do not. The capacity assessment should be proportionate to the situation and in an emergency, it is appropriate to act in the best interests of patients without a comprehensive assessment of their capacity.

3.1.3 Many factors can influence an individual's ability to make a decision including physical and or a mental health impairment. The decision to act in a patient's best interests must be balanced with the urgency of the situation. For instance, it may be appropriate to wait for a patient to regain capacity before making a decision, if it is believed that their impairment is temporary.

3.1.4 Just as impairment can be temporary, patients may have limited capacity to make some but not all decisions. The assessment of capacity should focus on the decision in question and should be conducted in accordance with the JRCALC UK Ambulance Service Clinical Practice Guidelines (JRCALC).

## 3.2 The Clinical Assessment

3.2.1 All patients must receive a full clinical assessment in accordance with the YAS structured approach to clinical assessment and the JRCALC guidelines.

3.2.2 Appropriate vital signs (as a minimum this must include pulse, respiratory rate and Glasgow Coma Scale) must be recorded, other observations should be made according to the presenting complaint. A National Early Warning Score 2 (NEWS2) or other appropriate early warning score such as the paediatric early warning score or the Prehospital Maternity Decision Tool should be calculated and recorded wherever possible.

3.2.3 A physical examination of the patient must be performed when appropriate always maintaining patient dignity. 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, or a stroke is not necessarily required.

3.2.4 Many of the patients that YAS attends have complex needs that may result in the assessment and management of their clinical needs difficult. Care should be taken when determining the capacity of these patients and a person-centred approach should be used when managing these patients.

## 3.3 Mental Health Needs

3.3.1 Patients presenting with a mental health condition should be assessed according to the YAS structured approach to clinical assessment and the JRCALC guidelines. Additionally, there are Mental Health Nurses within EOC that can offer assistance to clinicians on scene. YAS clinicians have access to a variety of care pathways specifically for individuals with mental health presentations. These can be accessed via the JRCALC app or by calling the clinical hub.

## 3.4 Dementia

3.4.1 The JRCALC guidance on the assessment and management of patients with dementia should be followed when assessing any patient with confirmed or suspected dementia. In addition, it may be appropriate to liaise with other health care professionals involved in the on-going care of the patient.

## 3.5 Learning Disability and Neurodiversity

3.5.1 Mencap describes a learning disability as a reduced intellectual ability and difficulty with everyday activities. These individuals may need support to understand complicated information and to interact with other or unfamiliar people. This should be considered when attending a patient with learning disabilities. Efforts should be made to ensure that communication is tailored to suit the patient and that they are given time and support to understand information.

3.5.2 Communication difficulties can occur for a variety of reasons; these may be secondary to a medical condition such as dementia or a previous stroke, an individual may be deaf

or hard of hearing, or they may not speak English. Neurodiversity encompasses conditions such as autism spectrum disorder, attention deficit hyperactivity disorder (ADHD), dyslexia, dyspraxia, and other neurological variations which can influence how individuals communicate, process information, and respond to their environment. These are not learning disabilities but represent differences in cognitive processing that may affect interaction, sensory tolerance, and situational understanding.

3.5.3 When attending a neurodivergent patient, clinicians should adopt a person-centred approach that recognises potential sensory sensitivities (e.g. to noise, light, or touch), slower information processing, and heightened anxiety in unfamiliar or overstimulating environments. Communication should be calm, structured, and unambiguous, allowing additional time for responses. Where possible, environmental stressors should be reduced and each action explained before it is undertaken.

3.5.4 Where the patient is supported by a carer, family member, or advocate familiar with their communication needs, their input should be sought — with the patient's consent — to facilitate effective understanding and engagement in decision-making. Capacity must not be assumed to be absent solely because of a neurodivergent presentation. Each decision should be assessed individually in accordance with the Mental Capacity Act (2005), and all reasonable adjustments must be documented within the ePCR.

## 3.6 Use of interpreters

3.6.1 Where a language barrier exists, clinicians must ensure that communication is adequate to obtain informed consent and to make safe clinical decisions. The preferred method of translation is via the Trust-approved Language Line service, which provides professional interpretation and maintains patient confidentiality.

3.6.2 If a professional interpreter is not immediately available and the situation is time-critical (e.g. life-threatening emergency where delay would cause harm), it may be appropriate to proceed using the best available means of communication until the patient is stabilised. This will be subject to dynamic risk assessment, and the mitigating strategy will need to documented.

3.6.3 In non-time-critical situations, particularly where a non-conveyance or referral decision is being considered, professional interpretation is the preferred mechanism of communication when the clinician cannot be confident that the patient fully understands the information being given. If relatives are on scene and the clinician is confident that the information being relayed is accurate then this is also an acceptable approach.

3.6.4 Relatives or friends may act as interpreters if:

- The patient explicitly consents to their involvement;
- No safeguarding or confidentiality concerns exist; and
- A risk assessment confirms that their use will not compromise the accuracy or neutrality of communication.

3.6.5 All decisions regarding the use (or non-use) of interpreters, including any risk assessment, must be documented in the ePCR, along with the name and relationship to the patient of any interpreter used.

## 3.7 Clinical Decisions and Responsibility

3.7.1 Ambulance service clinicians are required to make complex clinical decisions sometimes in challenging environments or with limited information. The Trust will

support clinical decision making when a reasonable decision has been based upon a comprehensive assessment that includes a thorough history and an appropriate physical examination that is based on the YAS structured approach to clinical assessment and the JRCALC guidelines. The assessment and the decision making (including pertinent negatives), where possible, should be documented.

3.7.2 Where clinicians on scene are unsure of or wish to discuss a patient's management plan and or the proposed treatment, they should phone the clinical hub and discuss the case with a registered health care professional.

3.7.3 When a clinician manages a patient with traumatic injuries, they should use the major trauma injury assessment tool. If the patient triggers steps 1 or 2 of the tool the clinician should follow the recommended action. For patients triggering step 3 of the tool, clinicians should consult a clinical navigator through the Clinical Hub or the Critical Care Desk, unless they are close to a major trauma centre. On scene clinical advice can be sought in the same manner via the Critical Care Desk if there is uncertainty as to the appropriateness of a trauma tool outcome.

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

3.7.5 Registered healthcare professionals such as paramedics or nurses have a professional responsibility to adopt the role of lead clinician, this applies even when mentoring a student or staff member of a similar or lower clinical grade.

3.7.6 Where clinicians of equal grades 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.

3.7.7 Where a specialist clinician is on scene for a specific patient group, i.e., a midwife for an obstetric patient, that clinician holds responsibility for the patient.

### 3.8 Accessing Alternative Care/Referral Pathways

3.8.1 Emergency and urgent care pathways are available through a variety of sources. When, following a full assessment, a patient is considered to be appropriate for specialist care such as PPCI, stroke, vascular services or major trauma then the pathway should be followed. When patients with low acuity or long-term conditions are assessed as being suitable for alternative care pathways, every effort should be made to access the pathway. It is the responsibility of individual members of staff to ensure that they operate within their own scope of practice when implementing alternative care pathways and referrals for their patient's.

3.8.2 The trust expects that staff will ensure they have access to their personally issued tablet computer or mobile phone for the duration of their duty. This may be required to access specialist care pathways, which may require the transmission of patient identifiable data or video consultation, though this must only be through approved pathways.

3.8.3 Staff must maintain oversight of current clinical notices and alerts which are accessed using their personal issued tablet / computer or trust mobile phone through the JRCALC app and can access the clinical apps approved by the trust to support their decision making where these are available.

## 3.9 Paediatrics

3.9.1 Decision making in paediatrics is a specialist area and YAS clinicians must follow their scope of practice and the NASMeD guidance as listed on the JRCALC app and in appendix C.

3.9.2 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 facilitate an immediate referral to another healthcare professional who can assume responsibility for their on-going care. This may include the parent self-referring to their own GP (including via online triage systems) or YAS crews referring via reception (note that direct clinician to clinician conversation is not required). Children who refuse treatment or transportation independently of their parent/guardian must be able to demonstrate Gillick competence. If you feel the child should go to hospital and the patient or family refuse, it is important to seek secondary advice remotely through the relevant specialist desk or clinical hub.

3.9.3 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 offers 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. However, if there is unequivocal evidence that the child has died and is clearly beyond medical help (as per JRCALC+ guidelines) then the child should be conveyed to an appropriate ED without resuscitation in progress unless the senior police officer with SUDIC responsibilities on scene requests that the body remains in situ. In this circumstance it must be made clear to the police that the child's body must be conveyed to an appropriate ED and that arrangements for this must be made prior to YAS leaving scene. Where children are on scene and have been in the care of a patient who requires conveyance to hospital arrangements must be made to ensure they are cared for. Guidance can be found in appendix D. Contact the critical care desk for advice in these instances**.**

## 3.10 Conveyance by Rapid Response Vehicle

3.10.1 For most 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 paramedic driving the RRV and no expectation will be placed on staff that patients should be conveyed by RRV.

3.10.2 A patient considered suitable for conveyance by RRV should have a NEWS score of 4 or less and a Glasgow Coma Scale score 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 table in appendix B acts as a guide but is not an exhaustive list.

### 3.11 Chaperoning

3.11.1 The apparent intimate nature of many clinical activities, if not practiced in a sensitive and respectful manner, can lead to misinterpretation and, very occasionally, allegations of abuse. Not understanding the cultural background of a patient can lead to confusion and misunderstanding. It is important that health care professionals are sensitive to these issues and remain alert to the potential for patients to be the victims of abuse. All staff must follow the YAS chaperone policy.

3.11.2 ***Doulas and Pregnancy-Related Care***: A doula is a trained, non-clinical support person who provides emotional, informational and practical assistance to an individual before, during and after childbirth. Doulas are not registered health professionals and therefore have no clinical decision-making authority, but they play an important role in supporting women and birthing people's comfort, advocacy and wellbeing. When attending a pregnant patient accompanied by a doula, YAS clinicians should:

- Recognise and respect the doula's supportive role, acknowledging that they may help the patient to remain calm, communicate preferences, and understand care options.
- Maintain professional boundaries at all times. The presence of a doula does not replace the requirement for a formal chaperone where intimate examinations or procedures are undertaken.
- Communicate clearly with both the patient and doula, explaining proposed assessments or interventions and ensuring that consent is obtained directly from the patient.
- Consider safeguarding and privacy—if any safeguarding concern arises, or if the doula's presence appears to inhibit open communication or compromise safety, clinicians should sensitively request private discussion with the patient and escalate concerns through normal safeguarding routes and seek remote support via the Critical Care Desk / senior clinician.

3.11.3 Document in the ePCR that a doula was present, the nature of their involvement, and any relevant discussions about consent or chaperoning.

3.11.4 Doulas can make a positive contribution to patient experience when roles are clearly defined. YAS staff should remain respectful of their presence while ensuring that clinical accountability, consent, safeguarding, and dignity are maintained in accordance with YAS policy and professional standards.

### 3.12 Patient Belongings and Medication

3.12.1 Patients' belongings remain their own responsibility unless it has been determined the patient lacks mental capacity. In these circumstances responsibility may lie with a travelling chaperone or where they are travelling alone the responsibility lies with the crew/attending clinician.

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

3.12.3 Green medication bags should be utilised to transport all patients' medications so that they are taken to the receiving unit with the patient. It is of paramount importance to take medications to the receiving unit, particularly time-critical medicines such as those

used in Parkinson's disease, epilepsy, diabetes, and certain mental health medications (for example first generation antipsychotics), where any delay or omission can have severe consequences for the patient, including a rapid deterioration in their condition. Simply recording a patient's drugs or taking a 'repeat prescription' is not sufficient and may result in missed medications and/or avoidable gaps in the ongoing care of the patient.

3.12.4 A notable exception occurs if the patient's condition necessitates an immediate transfer through a pre-alert to a unit for lifesaving care; in such cases, delays should be avoided, particularly if medications are not readily available.

3.12.5 The physical transfer of the medication bag ensures continuity of care and reduces the risk of errors in transcription and administration at the receiving facility. In cases where patients self-handover, ambulance staff must ensure that patients are fit to manage their own medication or that it has been given to a responsible carer.

3.12.6 Other patient belongings may be conveyed where it is reasonably practicable and does not interfere with patient care.

### 3.13 Discharge Of Care at Scene

3.13.1 Discharge of care occurs when, following assessment, the senior attending clinician determines that the patient does not require further immediate medical treatment, transport, or referral, and that it is clinically safe and appropriate for their episode of care with YAS to conclude at scene.

3.13.2 This differs from refusal, where a patient with capacity declines the recommended care despite advice to the contrary, and differs from referral, where another health care professional has accepted responsibility for the patient.

3.13.3 Before discharging care at scene, the attending clinician should ensure that:

- A comprehensive clinical assessment has been undertaken and documented in accordance with JRCALC and YAS assessment guidance.
- The decision is supported by available evidence, clinical reasoning and local pathways (for example, non-conveyance or community referral criteria).
- All red-flag conditions have been reasonably excluded and any required investigations or observations have been completed.
- Staff should act within the bounds of their scope of practice when considering discharging a patient and should seek advice when needed
- The decision aligns with the Safer Right Care framework and the principles of shared decision-making with the patient and/or carer.

3.13.4 The patient (and, where appropriate, their carer or family) should receive:

- A clear explanation of the assessment findings, rationale for discharge, and any follow-up or safety-netting advice.
- Confirmation of any self-care instructions, symptom monitoring, and when and how to seek further help.
- Written or verbal information appropriate to their communication needs (including interpreter use if required). Signposting to digital information is appropriate. The origin of information relating to safety netting should be documented.
- If the patient lacks capacity, discharge can only proceed when the decision is in the patients best interests, in conjunction with NOK, carers or other relevant healthcare professionals, or the decision is supported in a recognised care plan **and** a suitable responsible adult or healthcare provider is available to assume ongoing care.

3.13.5 All discharges at scene should include:

- Clear documentation of clinical findings, working impression with rationale, differential diagnoses, results of any investigations conducted at scene (e.g. ECG), and safety netting advice including specific signs and symptoms for which to trigger a call for help.
- The name and role of any clinician that has been consulted who has provided secondary decision support.
- Confirmation that consent and capacity were assessed, if required, and recorded.
- Any follow-up referral that was initiated.

3.13.6 Clinical accountability for discharge of care lies with the clinician who makes **and** documents the final clinical decision that ongoing ambulance or hospital care is not required at that point in time. In all cases:

- Any handover of clinical responsibility must be recorded within the ePCR;
- The clinician concluding care must ensure the patient's ongoing safety, documentation, and safety-netting are complete

3.13.7 Patients must not be asked to sign a refusal form where discharge has been clinically determined as safe and appropriate — refusal forms are reserved for cases where a patient declines the recommended course of care despite advice. When a patient is discharged from YAS care, the clinician who last assessed the patient assumes professional responsibility for the decision. The patient must not be asked to sign a refusal form, as the clinical assessment has concluded that ongoing ambulance or hospital care is not indicated.

### 3.14 Refusal of Treatment/Conveyance

3.14.1 Any person whose mental capacity is not impaired can refuse the assessment or intervention of ambulance staff. Ambulance staff should ensure that patients who refuse treatment (including transport or assessment) are informed of relevant risks and benefits of the proposed course of action to ensure that the patients refusal is informed.

3.14.2 Refusal is very different from discharge of care. When a clinician has assessed a patient and it has been determined that a patient does not require any further medical care or treatment then the patient should be informed that discharge from care is appropriate. When a patient is discharged from care the senior attending clinician is assuming responsibility for the discharge decision based on clinical appropriateness and the patient must not be asked to sign a refusal document.

3.14.3 When a patient makes an informed choice to decline advised treatment and / or transport, thereby choosing to go against the medical advice, clinicians should consider involving the patient's regular healthcare provider (for example, GP, Specialist care team, Crisis Team etc) if able to do so. Non-registered staff and NQPs must not accept a refusal in isolation and should jointly review cases with a registered healthcare professional (in most instances this will be through YAS Crew Line).

3.14.4 A refusal of care must be documented clearly and should include advice provided to the patient, along with all associated conversations with other Health Care Providers with names and roles / relationship to patient documented of individuals who have been consulted.

## 3.15 Refusal following overdose or self-harm

3.15.1 Where a patient presents following overdose or self-harm, clinicians must not presume incapacity but should recognise that decision-making may be impaired by the physiological or psychological effects relating to the incident or an underlying mental health disorder. The JRCALC+ guidance on overdose should be followed and the causative nexus should be actively considered to determine whether the cause of presentation (e.g., intoxication, self-harm, acute distress) is likely to impair the patient's ability to understand, retain, weigh-up or communicate information. Documentation should clearly outline factors that have informed this decision. It is highly unusual for a person with full mental capacity to make a genuine, informed decision to end their life; therefore, if staff believe this to be the case, senior clinical advice must always be sought to agree a safe and proportionate care plan. Clinicians should also consult TOXBASE to identify toxicity risk, assess mental capacity in line with the Mental Capacity Act (2005), provide clear, honest information to support informed consent, and escalate promptly to the Clinical Hub or Mental Health Team where there is doubt or concern.

## 3.16 Documentation

3.16.1 All episodes of patient care should be recorded on the electronic patient care record (ePCR) and completed in line with the ePCR completion guidance which is available on the YAS Intranet and the YAS structured approach to clinical assessment. When conveying a patient between healthcare facilities, all relevant documentation e.g., clinical records, should be transported with the patient and passed to the receiving clinician as part of the handover of care. The ePCR must always be checked and finalised by the senior clinician who is accountable for all clinical care and its documentation.

## 3.17 Conveyance Requirements – General

### *3.17.1 Patient destination*

3.17.1.1 The senior clinician must fully assess the patient before determining where the patient will be taken. Staff should consider the clinical needs of the patient, the facilities available at local hospitals and the local pathway/bypass agreements of destination hospital. Remote advice is available either within the specialist desks, clinical hub or EOC to support this decision.

3.17.1.2 If a patient has been identified as safe to make their own way to a treatment centre (for example via taxi), it is recommended that Newly Qualified Paramedics and non-registered clinicians contact the Clinical Hub or other appropriate remote care clinician to sense-check their decision-making and confirm safety-netting. Although this is not technically a discharge, it should be treated as such, as the clinician will be unable to act upon any deterioration once they have left the scene.

3.17.1.3 ***Face-to-Face HCP Conveyance Requests:*** Where a healthcare professional (HCP) has undertaken a face-to-face assessment and requested YAS to convey the patient to a designated destination, the patient must ordinarily be conveyed. YAS clinicians must still perform a structured assessment in line with JRCALC+ to identify red flags and determine eligibility for an acute pathway (e.g. stroke, STEMI, major trauma). If such a pathway or pre-alert to ED is indicated, it takes priority over the originally booked destination, even if this differs from the HCP's initial request.

3.17.1.4 ***Pre-Arranged or Specialty Destinations:*** Where an HCP has arranged a hospital admission after face-to-face review and no acute additional clinical concerns are identified on assessment, the patient should ordinarily be conveyed to the booked destination. If the booked destination is ED, clinicians should consider whether the patient is suitable for a direct specialty admission pathway (e.g. SDEC, frailty unit, surgical assessment). Before redirecting to an alternative unit clinicians must

- confirm patient suitability;
- ensure the receiving service has accepted the patient through a clinician-to-clinician conversation should the pathway require it; and
- record the accepting clinician's details on the ePCR.

3.17.1.5 This supports the principle of 'Right Patient, Right Place, First Time' and minimises unnecessary ED conveyance and duplication. Where specialties operate over multiple sites (e.g. Leeds, Hull, Sheffield), staff should consult the "*What Goes Where*" guidance within JRCALC+ Pathways and contact the correct specialty via the established route.

3.17.1.6 Palliative care patients may have a pre-arranged designated destination, as part of an end-of-life care plan, such as a hospice. This should be taken into account and discussed with the hospice, palliative care team and patient / NOK prior to departure to ensure the facility is able to accept the patient.

*3.17.2 <u>Removal from scene</u>*

3.17.2.1 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 with staff protecting the privacy, confidentiality, and dignity of their patients at all times. Staff should use available moving and handling aids supplied by the Trust. If other equipment is available, for example hoists, persons trained in use of the equipment must assist in the moving and handling of the patient.

3.17.2.2 Following assessment of the patients mental capacity and a dynamic risk assessment of the patient's mobility it may be determined that the patient could assist with their own transfer if deemed safe for the patient and the staff, i.e. shuffling forward on a chair before standing, bridging on a bed to aid the insertion of a slide sheet, or moving down their stairs at home on their bottom when environmental obstacles make the use of equipment potentially hazardous.

3.17.2.3 If staff estimate any factors to be beyond their capabilities as an ambulance crew, then assistance of a second ambulance or other services should be sought. 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.

3.17.2.4 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.

3.17.2.5 Should a patient continue to act against the advice given it must recorded on the ePCR and logged on DATIX.

### *3.17.3 Escorts*

3.17.3.1 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. In all cases the vehicle's maximum loading capacity must be observed.

3.17.3.2 Patients with dementia or learning disabilities should be escorted by relatives, carers, or advocates where possible. If this is not possible it should not prevent conveyance.

3.17.3.3 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 can 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, and staff should follow the unattended/unsupervised child process in appendix D.

3.17.3.4 Patients and escorts must always wear a seat belt. Attendants must wear seat belts, unless to do so would hinder their ability to care for the patient.

### *3.17.4 En Route*

3.17.4.1 In the event that a patient is deemed unstable/critically ill or requires a pre alert the senior clinician must 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.

3.17.4.2 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. If there is a competent person accompanying the patient, that person should be 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.

3.17.4.3 To ensure the safety of both patients and crew, appropriate safety restraints on ambulance vehicle seats or stretchers, such as seat belts and harnesses, should be used during transport. The decision to not use a harness should be based on a clinical dynamic risk assessment that reviews the patient's condition and the potential risks during transport, the rationale will need to be documented. Patients who are independent and seated in the ambulance must wear a seatbelt and be assessed to maintain a safe seated position.

3.17.4.4 Patients and escorts must always wear a seat belt. Crew members must wear seat belts, unless it is absolutely necessary to attend to the patient. Where possible the driver should be notified that the crew are unrestrained.

### *3.17.5 Upon Arrival*

3.17.5.1 Upon arrival at the destination the patient should be supported to leave the ambulance using the safest and most appropriate means for their clinical condition, considering the principles of 'fit-to-sit' and self-handover guidance (see Appendix ).

3.17.5.2 The terms “fit-to-sit” and “self-handover” describe different levels of patient independence in the emergency care pathway. “Fit-to-sit” refers to patients who do not require a hospital or ambulance trolley but still need ongoing monitoring or a formal handover, such as those receiving low-dose oxygen via nasal cannulae. In contrast, “self-handover” applies to fully independent patients who are clinically stable and can make their own way to the receiving department waiting room without requiring clinical supervision or further handover from ambulance staff.

3.17.5.3 All patients deemed suitable for self-handover are, by definition, also “fit-to-sit,” but not all “fit-to-sit” patients can self-handover. The key difference in this application is that patients who are deemed appropriate for ‘self-handover’ will be a YAS-led decision made by the ambulance clinician, whereas those deemed ‘Fit to Sit’ will be a decision made by the receiving unit, informed by the YAS clinicians. Recognising the vital role ambulance staff play in supporting the triage of patients, while mitigating any risks, will enhance patient experience.

3.17.5.4 Hospital portering chairs must not be used on ambulance ramps or tail lifts. These chairs are typically designed for internal hospital use and often lack adequate safety features such as seat belts or straps for outdoor use. Ambulance queues at the hospital can mean patients are required to be moved significant distances over outdoor surfaces that might be unsuitable or hospital portering chair use. A dynamic risk assessment should be performed that considers all these elements before transporting a patient.

### *3.17.6 Family and Friends*

3.17.6.1 YAS clinicians (especially extended role practitioners) may be approached by relatives, friends, and colleagues for their advice regarding medical problems they may have.

3.17.6.2 As with all Healthcare encounters, caution should be exercised in the advice given.

3.17.6.3 YAS clinicians should only provide advice or treatment to family members in acute, unscheduled, or emergency situations where failure to offer advice or treatment might be detrimental to the health or recovery of the individual. Any advice or treatment for minor conditions must be in line NHS guidance and any further care should be referred to the GP or most appropriate healthcare professional. Any advice or treatment for colleagues must be based on NHS guidance and can only be given if the individual clinician providing that advice has had the relevant training and it falls within their scope of practice.

3.17.6.4 As per the HCPC/NMC registrants have a duty to direct or refer the individual to a professional who can address the issue for them. YAS clinicians must not provide advice on any subject which is outside their competence and training.

3.17.6.5 YAS clinicians should not provide a diagnostic service for a relative, friend or colleague, except under the above circumstances or where they have accessed the service through the normal channels. Individuals should be advised to appropriately see their GP or self-refer e.g. urinalysis or direct x-ray referral.

3.17.6.6 Every patient encountered by a YAS Clinician whilst employed by YAS and using YAS equipment or treatments needs to be raised as an incident 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. The rationale for decisions made, including the patient's suitability for seated conveyance or independent arrival to the ED / treatment centre must be clearly documented.

## 4.0 Training Expectations for Staff

4.1 All patient facing staff and volunteers working on behalf of YAS should be appropriately trained in the assessment of patients and clinical decision making.

4.2 YAS operational staff should utilise the YAS structured approach to clinical assessment as well as the AACE JRCALC Clinical Practice Guidelines. Other local and national guidelines (e.g NICE) determined by the trust will be available on the JRCALC+ App to inform their clinical assessment and management of patients.

## 5.0 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 team leaders.

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.

## 6.0 Monitoring Compliance with this Policy

6.1 The application of this policy will be monitored through regular scheduled audit and will be reported back to the Clinical Governance Committee.

## 7.0 Consultation and Approval Process

7.1 The draft policy has been reviewed and discussed at Clinical Quality Development Forum and feedback acted upon. It will also go to the policy progression group both of which have representatives of all interested parties from within YAS including Staff side representation and patient representation.

7.2 This policy will be agreed by the YAS Clinical Governance Group

7.3 The policy will be approved by the Trust Management Group.

## 8.0 Equality Impact Assessment

8.1 ***Purpose***: Yorkshire Ambulance Service (NHS Trust) is committed to ensuring that this policy is applied equitably and does not discriminate, directly or indirectly, against individuals or groups who share protected characteristics as defined under the Equality Act 2010. The Trust also recognises its duty to make reasonable adjustments for colleagues and to promote inclusion for all patients and staff.

8.2 ***Equality Considerations:*** This policy has been reviewed to ensure it…

1) Promotes equal access to safe, effective care for all patients regardless of age, disability, gender, gender identity, marriage or civil partnership status, pregnancy or maternity, race, religion or belief, sex, or sexual orientation.

2) Embeds the Mental Capacity Act (2005) and Equality Act (2010) principles of autonomy, capacity, and reasonable adjustment.
3) Ensures communication needs are met through interpreter services (Language Line, British Sign Language, or advocate involvement) and tailored communication with neurodiverse or learning-disabled patients.
4) Recognises and mitigates the potential for health inequality, including for people with sensory impairment, low literacy, or limited digital access.

8.3 ***Reasonable Adjustments for Colleagues:*** The Trust will provide reasonable adjustments for staff involved in applying this policy, including:

- Accessible formats (large print, dyslexia-friendly font, digital screen readers).
- Devices that can be reasonably adjusted to meet individuals needs.
- Flexible or remote training delivery and opportunities for reflection for neurodiverse colleagues.
- Trauma-informed and psychologically safe supervision where exposure to distressing cases occurs through the YAS delivery of Core training and AACE Clinical Supervision Framework.
- Adjusted rostering or environment to support colleagues with sensory or physical needs.
- All managers and policy leads must ensure colleagues understand how to request reasonable adjustments through the People & OD or Equality, Diversity and Inclusion teams.

8.4 ***Equality Impact Outcome:*** No adverse equality impacts were identified during review. Implementation of this policy is expected to have a positive impact by reinforcing equitable clinical assessment, conveyance, and referral processes across the Trust.

## 9.0 Appendices

8.5 This Policy induces the following appendices:

Appendix A – Roles and Responsibilities
Appendix B – Conveyance by RRV
Appendix C – NASMeD Best Practice Guidance
Appendix D – Guidelines - Decision making if a child is unattended/unsupervised

## Appendix A – Roles and Responsibilities

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

The Consultant Paramedic for Clinical Practice and Development 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 YAS Academy will ensure any education delivered by the Trust is consistent with this policy.

Advanced Paramedic Clinical Leads and Team Leaders 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 an Advanced Paramedic Clinical Lead or their Team leader.

**Appendix B - Conveyance by RRV**

The following table acts as a guide for staff considering if transporting a patient by RRV is appropriate. It is not an exhaustive list and there is no expectation that patients would be conveyed by RRV.

| **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<br>• Sprains and strains where patient can mobilise safely to the vehicle<br>• Minor stable upper limb fractures where pain controlled.<br>• Small scalp wounds with minor mechanism of injury and GCS 15 throughout<br>• Eye problems<br>• ENT problems<br>• Minor Epistaxis (haemorrhage controlled)<br>• Transfer to walk in centre/GP/alternative care pathway where patient has been accepted by a HCP, but unable to make their own way<br>• Transfer home where the patient is able to self care and the journey time is less than 5 minutes | • Chest pain of cardiac origin<br>• Abdominal pain with guarding and tenderness<br>• Head injury with history of unconsciousness<br>• Collapse with history of unconsciousness<br>• Unstable diabetic<br>• Unstable epileptic<br>• Any patient with reduced GCS <15<br>• Mental health patients<br>• Anyone under the influence of Drugs or significant Alcohol consumption<br>• Unstable COPD/Asthma patients<br>• Any patient with a history of violence<br>• Patients that pose an IPC risk to the vehicle (incontinence etc.)<br>• Patients who have been the subject of an alleged sexual assault |

## Appendix C – NASMeD Best Practice Guidance

### Conveyance of children by operational ambulance clinicians in face-to-face settings July 2021

### Background

The conveyance policies relating to children amongst the UK ambulance services vary considerably. Many trust policies were originally based on the letter from the RCPCH sent to ambulance trusts in 2009 that recommended that all children under the age of 2 should be conveyed, however some trusts have moved away from this and have adapted local policies based on reviews of incidents including safeguarding incidents. This best practice guidance supersedes the RCPCH letter 2009 and is aimed at assisting ambulance services in developing their local paediatric procedures around conveyance.
In June 2019 the HSIB issued a safety recommendation to AACE:
'It is recommended that the Association of Ambulance Chief Executives agrees guidance that can inform its members on the competency and authority for staff to convey, refer and discharge children under five years who are subject to 999 calls.'
In July 2020 a workshop was held involving ambulance trust paediatric leads. The workshop agreed a number of principles that have helped inform this best practice guidance.
The definition of children in this guidance is up to the age of 18 years old.
This guidance is applicable where non conveyance is considered after a face-to-face assessment has been made by ambulance clinicians.
The underlying reasons for caution around a decision not to convey a younger child to hospital after an ambulance has been called have not changed in that:

- significant illness and injury can be harder to diagnose in very young children.
- underlying safeguarding issues can often be equally difficult to appreciate initially.

### Key principles

All non-registered clinicians and newly qualified paramedics (NQPs) MUST follow local trust guidance before discharging any child.
Some clinicians (for example advanced and specialist paramedics) may have received additional education in the care of children and should follow local guidance around conveyance.
Supported clinical decision making should be encouraged and wherever possible should be with a more senior Health Care Professional (HCP) (ideally with additional paediatric and/or specialist expertise e.g., GP, 111 integrated care, Clinical Advisory Service or paediatric community or palliative team).
When referring to another HCP, discussions involving the child and their carer should be encouraged, with the use of video consultation or speaker phone considered.
Ambulance clinicians speaking/referring to another HCP should inform them of their skill level, particularly if they are non-registered clinicians - in line with local procedures.
Ambulance clinicians referring to a HCP have a responsibility to provide accurate information so they can agree the most appropriate outcome. This will include all relevant clinical information including history taking and clinical assessments/observations. HCPs giving advice or accepting referrals will rely on the information they are provided with by the attending ambulance clinician.
There must always be an accurate record made in the patient care record of any discussions and referrals to another HCP including details of any agreed care plan and follow up including actions to be taken in the event of subsequent deterioration.
If non accidental injury (NAI) is suspected children must always be conveyed. NAI should be considered in children presenting with an injury, particularly in children aged under 5 years. Where the injury is not consistent with the age of a child (e.g. bruising in a non-mobile child) or

there are other concerns of NAI this should prompt a full examination of the patient including skin exposure to look for bruising or other signs of potential NAI. Refer to JRCALC safeguarding guidelines and local Trust guidance.
All children must be conveyed if they may have been exposed to potentially toxic substances, including button batteries or magnets.
All children not conveyed to hospital must be left in the care of an appropriate adult who has parental responsibility for the child (such as a parent or guardian).
All staff should be encouraged and supported to use 'Spotting the Sick Child' as an educational resource to maintain their skills - an interactive tool commissioned by the Department of Health and Health Education England to support health professionals:
https://spottingthesickchild.com/

**Children with mental health presentations/refusal of advice or conveyance**

All children must be conveyed or referred for further assessment if they have signs of mental health crisis, suicidal thoughts, or self-harm unless a mental health practitioner has made a full assessment and (i) recommends that conveyance is not required and (ii) there is agreement between professionals that an alternative pathway is both safe and desirable.
Where possible health care records should be accessed to establish if the child is known to any services, and if any care/crisis plans exist.
If the parent/legal guardian refuses, against advice, the conveyance of the child to hospital the ambulance clinician must speak to another HCP for a plan to be agreed. Ideally that HCP will know the child or young person, will be from their mental health team, or could also be their own GP. In some cases, it will be necessary to arrange a Mental Health Act assessment though the existing pathways in each trust.
If the child or young person is deemed to have mental capacity, then the clinician should speak to another HCP before discharging and document this discussion.
Some young people, particularly those over the age of 16 may be able to engage in interventions with a mental health professional that help to manage the immediate crisis.
Refer to local ambulance trust policies around consent, refusal and mental capacity in children.

**Conveyance to hospital**

All children under age one – any child with an identified (or suspected) injury or illness must be conveyed to the nearest Emergency Department (ED) which accepts children or else referred via a well governed and agreed local trust pathway (for example referred to a GP for a further clinical assessment).
Where clinical assessment finds no evidence of injury or illness, the request for ambulance help may be to address underlying social concerns or undisclosed parental stress or illness and therefore the child should either be (i) conveyed to ED or (ii) the ambulance attendance should be notified to the patient's GP as a minimum.
**Age 1 years to 5 years**- after face-to-face clinical assessment by a registered HCP this age group can be considered for handover of care and not conveyed to hospital. If considered for non-conveyance all clinicians **must make** a direct referral to another registered HCP as per local trust procedures. In most cases, during working hours, this will be the patient's own GP but out of hours may be via NHS111. A care plan or further follow up must be agreed at this point. If non conveyance is agreed, the receiving HCP will accept the handover of care and transfer of clinical responsibility at this point.
**Age 6 to 17 years**- after face-to-face clinical assessment by a registered HCP this age group can be considered for discharge or referral. The patient's GP should be informed of the child's need for an emergency ambulance attendance. Where the ambulance clinicians require the support of another HCP to avoid conveyance to ED this may be via the patient's own GP or other routes such as NHS 111, as per local procedures.

## Appendix D – Guidelines - Decision making if a child is unattended/unsupervised

### 1.0 Introduction

1.1 There may be a situation when a child or children are unattended, and the parent or carer is absent or unable to provide care and supervision to the child.

1.2 A child is someone under the age of 18 years

1.3 This document aims to give guidance to enable your professional decision making if this situation occurs.

1.4 This is YAS operational guidance, for 999 operational staff, to inform safe decision-making and professional judgement. In an emergency setting although the safety and welfare of the child is paramount, due concern has to be given to the medical care the adult/patient requires.

### 2.0 Facts to inform decision making

#### 2.1 The Law

2.1.1 The Law does not give an age when a child can be left alone. It is however an offence to leave a child alone if it places the child at potential or likely risk of harm.

2.1.2 Parents can be prosecuted if they leave a child unsupervised in a manner likely to cause unnecessary suffering or injury to health.

2.1.3 *'Parents can be prosecuted if they leave a child unsupervised 'in a manner likely to cause unnecessary suffering or injury to health'. Under the Children and Young Persons (England and Wales) Act 1933'.*

2.1.4 **"Loco Parentis" -** Loco Parentis is Latin for *"in place of a parent"* This term refers to the legal responsibility of a parent or organisation to take on some responsibility of a parent. Ambulance staff, volunteers, bank, agency, sub contractors and students may be acting as a 'parent' and facilitate decision making to keep the child is safe.

#### 2.2 Guidance

2.2.1 *The National Society for the Prevention of Cruelty to Children (NSPCC) , states:*

- *Children left under 12 are rarely mature enough to be left alone for a long period of time.*
- *Children under 16 should not be left alone overnight.*
- *Babies, toddlers and very young children should never be left alone.*

#### 2.3 Parental Responsibility

2.3.1 The mother and, if named on the birth certificate, the father have parental responsibility for a child until their 18th birthday. This would include a decision as to whom the child is supervised by or if left alone. For example - deciding whom to leave the child with or to leave the child alone; would be the parents decision. The parents take responsibility for the child even though they are not present.

## 3.0 Emergency Situations

3.1 In situations where a parent/carer does not have capacity to make safe decisions for the child; responsibility for the childs'safety will fall to the attending crew.

3.2 Please see the Safe Practice Guidance and Flow Chart.

## 4.0 Safe Practice Guidance

- You should always act in the childs' best interest to ensure the child is safe.
- The childs' needs are paramount.
- You should consider potential risks to the child if left alone.
- **If time critical – consider another resource – for the interim care of the child**
- You should ensure the child is with a known recognisable adult. If the parent is able, verbal consent would be obtained from the parent.
- If the parent is not present or not 'verbal' you should make arrangements to ensure the child is safe. **See Flow chart.**
- **Seek support from the Emergency Operations Centre or Clinical supervisor**
- Where possible you would document the name, address and telephone numbers of whom the child is with. i.e not the 'neighbour' or 'grandma' , but full demographic details.
- A verbal child would be able to confirm recognition of the adult.
- Consider the childs' safety. Is this an appropriate adult to leave the child with ?
- If you consider the decision of the parent or carer is not safe for the child, you would need to make alternative arrangements to ensure the childs' safety.
- If there is no apparent adult to care for the child/children – you could also discuss the situation with Children Social Care Emergency Duty team and/or the police.

4.1 If the situation has put the child at risk of potential harm or abuse due to lack of parental supervision or lack of parenting capacity, please consider making a safeguarding referral via the Clinical Hub.

## 5.0 Record keeping

5.1 If making a plan for a child/children ensure records clearly document:

- The name of the child and where is the child now.
- Name, Address and telephone number of the adult the child is with.
- Parental decision making – responsibility for decision/whether parental consent obtained.
- Immediate and future arrangements for child care.
- Rationale for the decision making process,i.e. why this decision was made, what was the decision, when and how was it made, by whom.

5.2 Consider the risk if you decide to:

- leave a child alone or unsupervised especially if under 16, even though a parent may suggest this is acceptable.
- leave a child alone at home – i.e. put key through the door.
- leave a child to care for other children
- leave the child without an adult in a public place – i.e. shopping centre, park, stair well, bus stop, school playground.

## Child unattended/unsupervised? Decision-making process