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Assessment, Conveyance and Referral of Patients (Emergency Operations)

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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 in order to determine a working impression of their presenting complaint
- 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.
- Working within their scope of practice to 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 the current UK Ambulance Service Clinical Practice Guidelines.

3. Process

3.1 Determining mental capacity and obtaining consent. This policy should be read in conjunction with the policy on Patient Consent to Examination or Treatment.

3.2 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.

3.3 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.

3.4 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).

3.5 The Clinical Assessment

3.6 All patients must receive a full clinical assessment in accordance with the JRCALC guidelines. A focussed patient history should be obtained to include presenting complaint, history of presenting complaint, past medical history, drug history, allergies and family/social history as required. Where a patient is critically ill or injured the history taking should be adjusted appropriately.

3.7 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) should be calculated and recorded wherever possible.

3.8 A physical examination of the patient must be performed when appropriate 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 or a stroke is not necessarily required.

3.9 Assessing patient's with complex needs

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

Mental Health needs

Patient presenting with a mental health condition should be assessed according to the JRCALC guidance. The traffic light tool for assessing patient with mental health conditions should be utilised as part of the overall assessment. 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.

Dementia

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.

Learning disability

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 interact with other/new 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.

Communication difficulties

Communication difficulties can occur due 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 of hard or hearing, or they may not speak English.
Where language is a challenge, clinicians can utilise ‘The Big Word’ translation service to assist them in communicating with the patient. It may be appropriate to use an interpreter if there is a carer or family member present, however discretion should be used and consideration given to the patient’s rights to confidentiality.

3.10 Clinical Decisions and Responsibility

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 thorough history, an appropriate physical examination and when it has been fully documented.

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.

When managing a patient with traumatic injuries clinician must utilise the major trauma triage tool and discuss the patient with the Major Trauma Centre Triage Co-ordinator (MTCTC).

It is important though 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.

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.

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.
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.

3.11 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.

3.12 Accessing alternative care/referral pathways.

All emergency and urgent care pathways are available on the JRCALC app or via the clinical hub or the MTCTC for major trauma. 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 must 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.

3.13 Paediatrics

The Royal College of Paediatrics and Child Health recommend that all children under the age of 2 must be conveyed to an appropriate emergency department following a 999 call to the ambulance service. For that reason all children under the age of two years must be conveyed to ED following a 999 call. 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). If the call originates from 111 then there is not an automatic requirement to convey the child and they may be referred using an approved pathway if clinically appropriate.

Children from the age of 2 to 12 who present with a feverish illness should be assessed according to JRCALC guidelines. Children presenting with traumatic injuries must be assessed using the JRCALC 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.

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. 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 as detailed in the JRCALC guidelines. 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 automatic conveyance to hospital is recommended.

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. Children who refuse treatment or transportation must be able to demonstrate Gillick competence.

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. 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 Police request that the body remains on scene.

3.14 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 and report it on DATIX.

3.15 Back up Guidelines for RRV Clinicians

To assist staff and to provide timely backup to the most serious clinical cases the RRV backup guidance should be followed. 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 in full in the guidance document along with some examples as well as the divert criteria for each category.

3.16 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. 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.

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.

3.17 Patient belongings and medication

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.

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

Green medication bags should be utilised to transport all patients' medications so that they are taken to the receiving unit with the patient. This is vital in ensuring that the patient's drug regime is maintained upon their admission to hospital. 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 on-going care of the patient.

3.18 Refusal of treatment/conveyance

A patient with mental capacity is completely within their rights to refuse the assessment, treatment or transportation offered by the clinician as long as they have been provided with all the relevant information that enables them to make an informed decision. 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 clinician is assuming responsibility for their decision and the patient must not be asked to sign a refusal document.

When a patient makes an informed choice to decline treatment and or transport then in these situations the clinician should seek to negotiate with the patient and involve their regular healthcare provider/General Practitioner/ Specialist etc.

A refusal of care must be documented clearly, along with all associated conversations with other Health Care Providers.

3.19 Documentation

All conveyances and non-conveyances of patients should be recorded on the electronic patient care record (PCR) and completed in line with the PCR completion guidance which is available on the YAS Intranet. 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. The PCR must be signed off and completed by the senior clinician who takes full responsibility for all clinical care and its documentation.

Documentation must 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.
- 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.

3.20 Conveyance requirements – General

3.21 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. Where this revision may lead to a patient not being conveyed, a discussion with the original requestor should take place first.

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.

3.22 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 it must recorded on the PRF and logged on DATIX.

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.

3.23 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 Safeguarding (Children, Young People and Adults at Risk) Policy).

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.

If deemed appropriate and where possible, assistance dogs may be conveyed with the patient providing they can be safely restrained within the ambulance.

3.24 En Route

In the event that a patient is deemed unstable/critically ill or requires a pre alert 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 a patient refuse to wear a seat belt a risk based assessment must be made and this must be documented. Where the clinical condition of the patient requires an essential conveyance to hospital then the patient's decision to not wear a seat belt must be recorded and the patient can be conveyed. Where a patient with a low acuity condition that does not require essential hospital treatment refuses to wear a seat belt, conveyance can be refused. 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. 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.

3.25 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.

3.26 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/NMC 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. If a colleague is taken ill suddenly and requires treatment a running call must be requested via EOC.

- Provide advice or treatment for colleagues on any condition which might have an occupational element e.g. low back pain in Emergency Medical Dispatchers. Except where that treatment or advice is part of care provided as part of an incident for which there is a call logged on the CAD. 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 case attended 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.

3.27 Incidents that have not been allocated via EOC

It is not uncommon for a YAS clinician or crew to be summoned via means out with 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, or advice given to the individual to contact ambulance via 999. Where the clinician/crew are available to deal with the incident, this should be communicated with EOC and an incident created on CAD.

3.28 Maintaining communication on scene and during conveyance

There are occasions where a crew may become separated on scene. This should be dynamically 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.

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]. cABCDE should be utilised when assessing potentially traumatically injured patients.

4.2 All YAS clinicians will undertake initial training either with a Higher Education Institution or the YAS Academy. Ongoing training needs 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).

4.3 YAS operational staff should utilise the AACE JRCALC Clinical Practice Guidelines along with other local and national guidelines (e.g NICE) determined by the trust (JRCALC Plus App) to inform their clinical assessment and management of patients.

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 2019 (JRCALC Plus App)
- NICE Guidelines [CG160] 2013, updated 2017. Fever in under 5s: assessment and initial management

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 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 AACE Clinical Practice Guidelines (JRCALC Plus App) 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 draft policy will be discussed at Clinical Quality Development Forum and amendments made with stakeholder consultation.

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 B

Guidelines - decision making child if a child is unattended/unsupervised

1.0 Introduction

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.

A child is someone under the age of 18 years.

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

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

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

'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'.
"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
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.

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

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.
Please see the Safe Practice Guidance and Flow Chart.

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.

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.

4.0 Record keeping

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.

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.

Flow Chart - Operations Child unattended/unsupervised decision making process