London Ambulance Service NHS Trust

Policy Statement of Duties to Patients

DOCUMENT PROFILE and CONTROL.

Purpose of the document: to safeguard the interests of our staff and our patients and, by so doing, support and promote the goals of the London Ambulance Service.

Sponsor Department: Medical Directorate

Author/Reviewer: Consultant Paramedic. To be reviewed by July 2021.

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Amendment History			
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13/06/18	5.4	Consultant Paramedic and Deputy Medical director	Minor changes to Section 5
07/06/2018	5.3	Consultant Paramedic Clinical Advisor to Legal and Governance	Change and update to section 5
25/10/16	5.2	IG Manager	Document Profile & Control update and minor changes
13/10/16	5.1	Asst Medical Director	Minor amendments required by PMAG
05/10/16	4.3	IG Manager	Document Profile & Control update
21/09/16	4.2	Consultant Paramedic	
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***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
	Public Interest Disclosure Act 1998	
HS 011	Incident Reporting Procedure	
TP/009	Policy for Access to Health Records, Disclosure of Patient Information: Protection and use of Patient Information	
TP 027	Infection prevention and control policy	
OP/014	Procedure for Managing the Conveyance of Patients	
OP /031	Policy & Procedure for Consent to Examination or Treatment.	
OP/045	Procedure for Patients Suspected of Alcohol and/or Drug Intoxication	
TP/ 034	'Being Open and Duty of Candour Policy & Procedure	
	Health and Care Professions Council:https://www.hpc-uk.org/	
	General Medical Council: https://www.hpc-uk.org/	
	Nursing and Midwifery Council: https://www.nmc.org.uk/	
	General Pharmaceutical Council: https://www.pharmacyregulation.org/	
	Principles of Emergency Medical Dispatch. 5th Edition	

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1. Introduction

1.1 As employees of London Ambulance Service NHS Trust (LAS) staff, whilst on duty, have a professional duty and obligation to maintain a high standard of practice and care in order to serve the best interests of patients and their relatives and carers. Staff are required to be ready and willing to work at all times during their contractual hours, and to ensure that the appropriate levels of skill and care are provided to patients, commensurate with Service procedures.

1.2 It is an integral part of the duties that staff undertake as employees to observe proper standards of personal integrity and honesty. It is also the responsibility of every member of staff to protect all confidential information (subject to the rights under the Public Interest Disclosures Act 1998) and in accordance with the LAS policy on confidentiality. *(Please refer to TP/009 'Policy for Access to Health Records, Disclosure of Patient Information, Protection and use of Patient information').*

1.3 These obligations start from the initial call for LAS assistance, whether this is the receipt of a telephone call to the service, text message via the emergency SMS service or a direct approach to a member of LAS staff by a patient or third party. It does not cease until, where appropriate, the patient is handed over to the care of another competent individual who is able and willing to provide appropriate continuing care (see Appendix 1, Criteria of Competency).

1.4 Only by all London Ambulance Service staff members recognising and working in accordance with these statements can we safeguard the interests of our staff and our patients and, by so doing, support and promote the London Ambulance Service's goals of:

- Providing appropriate and clinically effective care that inspires public confidence and patient satisfaction.

- Involving, developing and supporting each other in the continual improvement of the service we deliver.

- Providing leadership and direction in an environment that encourages involvement and teamwork at every level.

2. Scope

This policy covers the obligations of all London Ambulance Service staff in serving patients, their relatives and carers.

3. Objectives

To confirm the responsibility of all LAS staff to always:

1. Strive to preserve life and alleviate suffering.

2. Care for each patient as an individual, with courtesy, respect and dignity.

3. Avoid any action that is detrimental to the interests of the patient or to those involved in the patient's care.

4. Responsibilities

4.1 These professional obligations require that all LAS staff have a duty to:

- Always work within LAS Trust policies and procedures.

- Always act in the best interests of patients.

- Recognise and work within the limits of their professional competence by undertaking duties and responsibilities which they are able to perform in a safe and skilled manner and for which they have appropriate training, education and experience.

- Provide clinical leadership by assuming overall responsibility for a patient (or task) once it has been established that they have a higher level of competency than other staff on scene.

- Handover the management of a patient (or task) where there is a more senior clinician in attendance, if appropriate. Note that the more senior clinician holds primacy of care regardless of any similarities in skillset.

- Obtain informed consent when appropriate to give treatment (except in an emergency).

- Keep clear, accurate and up to date patient records which report the relevant clinical findings, decisions made, and all treatment administered to the patient.

- Deal fairly and safely with the risks of infection *(Please refer to the Infection Prevention and Control Policy TP 027)*

- Protect information in records from being lost, damaged, accessed by someone without appropriate authority or tampered with.

- Maintain and improve their professional knowledge, skills and competence through ongoing personal development.

- Observe the professional principles of integrity, honesty and patient confidentiality. Information about patients should be treated as confidential and used only for the purposes it has been provided for. Personal or confidential information should not be knowingly released to anyone who is not entitled to it.

- Refrain from knowingly participating in any act or deed that could be deemed unethical.

- Limit their work or stop practising if their performance or judgement is affected by their health (physical or mental).

- Do nothing to undermine public confidence in the Service.

- Maintain and promote the professional standing of the LAS in the wider health care setting and with other emergency services and agencies.

- To support the Duty of Candour to promote openness and transparency and ensure that incidents affecting patient safety are promptly and appropriately reported.

4.2 **LAS Trust Board**

The LAS Trust Board has duties to its employees to ensure that:

- All policies and procedures are regularly reviewed to ensure that they reflect current best practice and are evidence-based.

- All relevant health and safety requirements are achieved.

- All reasonable and practicable steps are taken to ensure that staff work in an environment which is free from violence, abuse and/ or discrimination.

- All staff have access, as far as reasonably practicable, to support services such as professional and personal development, occupational heath services and confidential counselling.

- All staff concerns about patient care are addressed.

- Staff are well educated and trained appropriately in all aspects of patient care.

5. Defining 'Duty of Care', 'Standard of Care' and 'Primacy of Care'

5.1 The terms, 'duty of care', 'standard of care' and 'primacy of care' are sometimes misunderstood, or misinterpreted. There is no one definition of 'Duty of Care' although the base principles were laid down in the case of Donoghue v Stevenson in 1932[1]. All these terms have at their core the principle tenets of acting reasonably, with safety and to some form of standard(s) where applicable.

It is expected of all staff that they know and recognise their own scope of practice. In particular they are expected to know when to defer to someone who has the skill level/ experience to manage a patient better than they, in any given circumstance. By this same token all staff are expected to recognise when they can offer better management/ support than that being delivered in a given circumstance.

All registered clinicians are reminded of their respective responsibilities as required by relevant regulatory bodies. For example (not an exhaustive list):

Health and Professions Council (HCPC)
- Paramedics
- Social Workers

General Medical Council (GMC)
- Doctors

Nursing and Midwifery Council (NMC)
- Nurses
- Midwives

General Pharmaceutical Council (GPhC)
- Pharmacists

Staff undertaking pre-registration education programmes should be aware of any responsibilities required by the HCPC, NMC, GMC, or GPC as appropriate.

Staff certified by the International Academy of Emergency Medical Dispatch are required by the Academy to maintain obligations to maintain professional standards of technical competence, morality and integrity and must abide the Academy's Codes of Ethics and Conduct.

5.2 Primacy of care

Primacy of care is the area where there can be a blurring within the grade(s) and/ or professions of staff on scene. In general terms two basic principles apply here;

1.) The first qualified person on scene will initiate treatment and continue to advise/ direct and carry out treatment, until that episode of care is concluded, or until they hand the patient over to another appropriate member of staff or healthcare professional (HCP) etc…, and:

2.) Where there is more than one member of staff on scene it is the more senior member of staff on scene in terms of **clinical** qualifications who **must** take responsibility.

Specific guidance for paramedics

Where they are the most senior ambulance clinician on scene, paramedics must use sound clinical reasoning to ensure that patients receive care from the most appropriate available ambulance clinician.

It is recognised that in most cases non-paramedic ambulance clinicians are more than capable of caring for patients, however proper consideration of the patient's condition, and the potential for deterioration, must take place before care is delegated to a less qualified clinician. This is particularly pertinent when paramedics are sharing driving duties as well as when handing over care to a non-paramedic crew as a solo responder.

It is equally essential that the skill level of ambulance clinicians is accurately established in order for clinically appropriate task delegation to take place, and that colleagues are empowered to raise concerns if it appears that patient care outside of their scope of practice has been delegated to them; this includes assessment and monitoring as well as practical interventions.

It is unacceptable for paramedics to delegate care of patients to non-paramedic ambulance clinicians where the patient needs, or is likely to need, care that only a paramedic can provide.

The paramedic must always be able to clinically justify why they did/ did not opt to attend.

The above does not however mean that a lower qualified member of staff can totally abrogate their duty of care to a patient. If that lower qualified member of staff is aware that something is not correct, be that by an act or omission, then they themselves have a duty to speak up and attempt to rectify the problem. In the rare event of problems of primacy of care arising, it is important that first and foremost staff on scene do not lose sight of caring for the patient.

5.3 **Standard of Care**

All staff have a duty of care to a patient and it is how the standard of care is carried out that will determine whether or not staff have been negligent in caring for a patient. There is an expectation that as staff progress in terms of grade and experience, they will provide a higher standard of care than those who do not possess that grade or experience. Clinically qualified staff having managerial positions over staff are expected to behave in accordance with the above principles.

When differences of opinion do occur the overriding principle in every member of staffs mind **must** be the well being of the patient –"first (or above all) do no harm"[2] [3].

Should a member of staff fail to act in accordance with the above procedures and guidance they may be considered negligent. The test would be to establish that there was; 1.) a duty of care to the patient, and that; 2.) that duty of care was carried out to an appropriate standard. In establishing whether or not staff have acted properly towards any patient the *Bolam* test is the most likely to be used (with the exception of cases where the allegation relates to consent, see 6.5). The essence of this test is that staff will be judged against the standards of their peers, taking into account any guidance, procedure or regulation that might impact upon their practice in the given situation[4].

A clinician who allows a lesser qualified member of staff to treat a patient is not *per se,* negligent in their actions **but**, that clinician **must** be sure in their mind that the standard of care given by that member of staff is appropriate to the patient's care needs. Thus at the bedside, roadside or en route to hospital the clinician may well be happy to allow a member of staff to provide treatment to the patient, but if it is apparent that the patient's condition is worsening then it is expected for that clinician to step in and take over the treatment.

5.4 Within the daily operation of the LAS, staff are frequently required to work alongside colleagues from other emergency services and other agencies. Such occasions generally arise where other services are already on scene, or where their assistance has been requested by LAS crews in attendance.

5.5 Other than in the presence of a more qualified clinician (as outlined above, and in 5.6 below), it is an absolute requirement that the most qualified and competent member of LAS staff assumes overall responsibility for the patient's clinical management at all times. Clearly, the safety of LAS staff, along with the patient and others involved in the patient's management is paramount. However, in the comparatively rare circumstances where scene safety directives (LFB, HART team

etc,) preclude direct contact between LAS staff and the patient, the most qualified LAS crew member must still maintain an overview and management of the patient's condition wherever possible.

5.6 In situations where other healthcare professionals are involved in the patient's management, it is imperative that the 'responsible' clinician is agreed from the outset. Where 'inter-hospital transfers' are concerned, the accompanying clinician from the referring hospital may be the 'responsible' clinician. This decision should be agreed and communicated from the outset. However, although the accompanying clinician may have 'primacy of care', the ambulance clinician cannot abrogate their responsibility to ensure the patient is adequately monitored and where appropriate, the patient's observations recorded and treatment provided as and where necessary.

There may be occasions in the out of hospital environment, where another Health Care Professional (most commonly a Doctor) offers to take the lead or assist in the delivery of care. This should only be accepted if they propose to carry out a skill that is outside the skill set of the ambulance clinicians on scene and if the crew are satisfied beyond reasonable doubt that the non LAS clinician can prove their identity. Their name and registration number (if available) should be recorded on the PRF. Their identity must be openly communicated between all parties on scene.

Where a Doctor or other relevant healthcare professional, who has established a duty of care to a patient, requests that the ambulance crew do something which is outside of their clinical practice guidelines, (i.e. the crew are asked to undertake something that would normally require the patient to go to hospital or give a drug outside of UK Ambulance Services Clinical Practice Guidelines or LAS Patient Group Directions) then the crew must seek senior clinical advice from the Clinical Hub who can consult the clinical on call if required.

In addition to this, the clinician must ask the doctor or other relevant healthcare professional if this intervention is within their scope of practice. In all cases the doctor or other relevant healthcare professional must annotate the patient report form with their reasoning and sign the form to that affect including their GMC or professional bodies' registration number. It should be noted that this situation will rarely happen given the majority of healthcare professionals are not specialist in pre-hospital care.

5.7 Of the other emergency services, LAS staff predominately work alongside colleagues from the Metropolitan Police Service. While it is recognised that these situations/ incidents can be complex and occasionally very difficult, there must be no doubt that the LAS retains overall responsibility for managing the patient's clinical condition at all

times. This remains the case even in circumstances where the police are required to provide force and restraint in dealing with a specific patient.

(Please refer to OP/014 'Managing the Conveyance of Patients' and OP/045 'Procedure for Patients Suspected of Alcohol and/or Drug Intoxication')

5.8 The key to the successful management of all such situations is communication, with close liaison and teamwork between all agencies on scene. As in all cases, the importance of recording and documenting all observations, decisions and actions taken cannot be overemphasised. This includes noting the shoulder numbers of police, and/ or the names and designation of other individuals involved. It is imperative that all such information is captured on the Patient Report Form/ Continuation Sheet as necessary.

(Please refer to the User Guide via 'the pulse', under 'Patients' and 'Assignment Record and Clinical Record Form')

5.9 Staff should remain mindful that they can seek advice via EOCat any time, with further assistance provided by the Clinical Support Desk. The desk is staffed by experienced paramedics who have been trained to support staff with patient related clinical problems, as well as any aspect of patient assessment or treatment.

6. Non-Conveyance

(OP/014 - 'Managing the Conveyance of Patients' and the PRF User Guide contains further and fuller guidance for this topic).

6.1 It is essential that ambulance crews make every effort to undertake a full patient assessment and initiate treatment and provide appropriate onward care. Wherever possible at least two sets of clinical observations should be recorded on the PRF. If for any reason it is not possible or appropriate to record observations, then those reasons must be documented on the PRF in the free text area.

(Please refer to the User Guide via 'the pulse', under 'Patients' and 'Assignment Record and Clinical Record Form')

6.2 Following comprehensive assessment, staff should advise the patient of their key findings, together with the rationale of the subsequent treatment regime. Ordinarily, this will include conveyance to hospital, or referral to another healthcare professional via an appropriate alternative care pathway, or discharge with treatment and/ or advice. Staff will be aware of the increasing range of alternative care pathways available on both a local and Service-wide basis, all of which are fully detailed on 'the pulse' and Directory of Services (DoS)

6.3 Such discussions with the patient should also include family members, carers and friends etc., as appropriate to the individual circumstances of the assignment. While patient confidentiality must be respected at all times, it is recognised that open communication and broad acknowledgment of the patient's choice of treatment options are key factors to successful on scene management.

6.4 Where the LAS has been called by a healthcare professional, the attending clinicians should identify the purpose of the referral. Where the request includes instructions to convey the patient to a specific destination, this should normally be complied with. Where the patient provides informed refusal, and has the capacity to do so, the referring clinician should be informed. If the patient lacks capacity, a best interest decision must be made according to the Mental Capacity Act (2005) Ambulance staff must never refuse to convey the person for whom an ambulance has been called, unless there is evidence that the situation that prompted the call has changed.

Where the healthcare professional has requested LAS attendance to attend to undertake a clinical assessment and/ or provide appropriate care this should be established and the call managed in the normal way. Consideration should be given to contacting the referring clinician if appropriate.

6.5 Where a patient is reluctant to be conveyed to hospital, the clinical needs of the patient must determine the degree to which staff attempt to persuade the patient to travel. It is, therefore, essential that all patients are thoroughly assessed, and every appropriate effort made to persuade the patient to travel. The further option (where relevant) of discussing the case with the patient's primary healthcare provider, e.g., GP, District Nurse etc., should also be considered.

Staff must ensure that where a patient refuses care and/ or conveyance against the clinical advice of the attending clinician it is the responsibility of the clinician with primacy of care to ensure that the patient is provided with the necessary information to ensure the decision is fully informed and that they have sufficient mental capacity to make the decision[5].
(Please refer to the full version of OP/014 'Managing the Conveyance of Patients')

6.6 Where the patient continues to decline conveyance despite appropriate advice, all relevant information must be recorded on the PRF, including two full sets of patient observations (20 minutes apart) wherever possible. The patient's capacity to refuse help should be formally assessed and documented. Where a patient lacks the capacity to make

an informed decision crews may where appropriate, act under the Mental Capacity Act 2005 to effect conveyance.
(Please refer to OP/031 'Policy for Consent to Examination or Treatment' via 'the pulse').

7. LAS Staff not on Duty

7.1 Whilst off duty, LAS staff may find themselves in a situation where they are asked to act as a "Good Samaritan". Legally, there is no requirement for an off duty member of staff to act as a Good Samaritan and the LAS is not legally required to support any member of staff who chooses to act as such. However, as a general rule, in such circumstances the LAS Trust Board will support any member of staff who accepts a duty of care in acting as a Good Samaritan, providing that they:

- Are in the United Kingdom at the time (to meet the requirements of the NHS Litigation Authority indemnity scheme).
- Have due regard for their own health, safety and well-being, and that of others.
- Work strictly within their limits of training, competency and certification as they would whilst on duty.
- Make best efforts to ensure that full ambulance support has been requested in the interim.
- Give a full hand over to the arriving ambulance response or other health care professional on scene.

Registered healthcare professionals should be aware of the expectations of their regulatory bodies in respect of obligations when not on duty.

IMPLEMENTATION PLAN				
Intended Audience	For all LAS staff			
Dissemination	Available to all staff on the Pulse			
Communications	Revised Procedure to be announced in the RIB and a link provided to the document			
Training	Continuous throughout core clinical education and training, and also via CPD activity.			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**
Duty of Care, Standard of Care, Primacy of Care and Non Conveyance	Quarterly review via the Clinical Performance Indicator process (CPI), and Incident Reporting System Complaints monitoring Inquests Serious Incident reviews	Clinical Audit and Research Unit, and Health Safety and Security Team report to Area Quality Meetings	Clinical Safety and Standards Committee	Learning disseminated via various mechanisms including Medical Directorate Bulletins, Area Quality Meetings, Routine Information Bulletins, etc
Advice provided by Clinical Support Desk in respect of above aspects	Monthly review using internal audit tool	CHUB Management Team and Control Services Governance and Quality Group		

Appendix 1

Criteria of Competency for Carers

A competent individual is defined as:

- One who is able to understand the information relevant to the decision.
- One who is able to retain that information.
- One who is able to use or weigh that information as part of the process of making the decision.
- One who is able to communicate his decision by using any recognisable means of communication.

The factors that will determine that the individual is capable of looking after the patient are:

- Has access to a telephone.
- Knows the patient's General Practitioner's contact details.
- Is able to communicate with the emergency services.

The greater the clinical risk of the incident, the greater the competency required of the person accepting responsibility for the patient and the lower the threshold for contacting other agencies. Only after confirming that the above criteria have been met should ambulance staff deem it appropriate to leave a patient in that person's care.

[1] *Donoghue v. Stevenson* [1932] All ER Rep 1; [1932] AC 562; House of Lords
[2] Gillon, R. (1985) Philosophical medical ethics : Chichester, Wiley
[3] Jackson, E. (2006) **Medical law: Text, cases and materials** : Oxford, OUP
[4] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582
[5] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11