London Ambulance Service NHS Trust

Managing the Conveyance of Patients Policy and Procedure

DOCUMENT PROFILE and CONTROL

Purpose of the document: To define the process for managing the conveyance/ non-conveyance of patients

Sponsor Department: Medical Directorate

Author/Reviewer: Senior Clinical Adviser to the Medical Director. To be reviewed by November 2019.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
30/11/2016	3.2	IG Manager	Reference to new Equality Analysis added
24/11/2016	3.1	Head of Governance and Assurance	Document Profile and Control update.
22/11/2016	2.8	Interim Deputy Medical Director	Further Amendments following PMAG 10-11-2016
20/10/16	2.7	Senior Clinical Adviser to the Medical Director	Further amendments
18/08/16	2.6	Head of Governance	Amendments to reflect new job titles and committees etc
18/08/16	2.5	Senior Clinical Adviser to the Medical Director	Further revisions
22/02/16	2.4	IG Manager	Document Profile and Control update.
21/02/16	2.3	Senior Clinical Adviser to the Medical Director	Review and amendments esp to sections 9.2, 11.3, 18,19. New sections 20-24.
14/05/13	2.2	Senior Clinical Adviser to the Medical Director	Minor amendments
18/09/12	2.1	Senior Clinical Adviser to the Medical Director	Minor amendments following approval
03/09/12	1.4	IG Manager	Document Profile & Control update
13/08/12	1.3	Staff Officer to the Medical Director	Addition of OP/ 020 (Section 11). Addition of guidance for non-conveyed children aged under five. Minor updates to all sections.
21/06/12	1.2	Senior Clinical Adviser to the Medical Director	Monitoring section updated (new Implementation Plan).
20/09/10	1.1	Medical Director, Senior Clinical Adviser to the Medical Director, Governance and Compliance Manager	Minor changes – Links to Related documents/ references, and section 16 updated.

25/08/10	0.3	Senior Clinical Adviser to the Medical Director	Addition of Patient Groups - Conveyance Requirements table.
15/04/10	0.2	Senior Clinical Adviser to the Medical Director	Added scope, responsibilities. Refined objectives, expanded monitoring and non-conveyance of patients
03/02/10	0.1	Senior Clinical Adviser to the Medical Director	First draft

***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.

For Approval By:	Date Approved	Version
PMAG	24/11/2016	3.0
SMT	14/09/2012	2.0
EMT	15/09/2010	1.0
Ratified by Trust Board (If appropriate):		

Published on:	Date	By	Dept
The Pulse (v3.2)	30/11/16	Governance Administrator	G&A
The Pulse (v3.1)	29/11/16	Governance Administrator	G&A
The Pulse (v2.2)	14/05/13	Governance Co-ordinator	GCT
The Pulse	05/10/10	Governance Administrator	GCT
LAS Website (v3.2)	30/11/16	Governance Administrator	G&A
LAS Website (v3.1)	29/11/16	Governance Administrator	G&C
LAS Website (v2.2)	14/05/13	Governance Co-ordinator	GCT
LAS Website	05/10/10	Governance Administrator	GCT
Announced on:	Date	By	Dept
The RIB	29/11/16	IG Manager	G&A
The RIB	09/10/12	IG Manager	GCT
The RIB	10/10	Governance Administrator	GCT

Equality Analysis completed on	By
10/11/16	Medical Directorate team
Staffside reviewed on	By
	Staffside Representative

Links to Related documents or references providing additional information		
Ref. No.	Title	Version
	IHCD Training Manual	
	Road Traffic Act	
	LAS Infection Control Manual	
TP/014	Procedure for Ambulance Observers	
OP/001	Dress Code for Uniformed Staff	
	Health and Safety at Work Act	
HS005	Manual Handling Policy	
	Data Protection Act 1998	
OP/031	Policy for Consent to Examination or Treatment	
	NPIA/ACPO – Guidance on Responding to People with Mental Ill Health or Learning Disabilities	
OP/040	Policy advising staff where deviation from guidelines is considered	
LA4	Patient report form (PRF)	
TP/003	Policy Statement of Duties to Patients	
OP/010	Location Alert Register	
OP/028	Advanced Directive/ PSP	
TP/018	Suspected cases of Child Abuse	
TP/019	Suspected abuse of Vulnerable Adults	
LA052	Incident Reporting Form	
HS012	Violence Avoidance and Reduction Procedure	
HS011	Incident Reporting Procedure	
	Human Rights Act	
	Mental Capacity Act (2005)	
LA5	Assessment of Capacity form	
	Mental Health Act – Section 136	
	Mental Health Act – Code of Practice	
	BMA Mental Capacity Act Guidance	
	DH Guidance - Working Together to Safeguard Children	
	UK Ambulance Services Clinical Practice Guidelines 2016s (JRCALC)	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

The London Ambulance Service NHS Trust (LAS) attends a diverse range of patients, often in unique and demanding circumstances. This procedure aims to capture the entire patient journey from the point a resource arrives on scene to the point of discharge from ambulance service care. The actions we take to provide care are crucial in providing patients with a timely and appropriate experience. In order to provide fluid care we need to maintain close working relationships with partner agencies and care givers.

2. Scope

This policy provides overarching guidance to staff in relation to the appropriate treatment, conveyance and referral of patients. It does not seek to provide detailed guidance, but does signpost staff to the relevant detailed guidance/ policy where required.

This policy applies to any grade of staff who will be assessing, treating or conveying a patient whether in an emergency situation or a non-emergency situation.
This policy applies to all patient groups. Where required advice/ guidance regarding specific patient groups, such as children or vulnerable adults, will be distinctly identified.

3. Objectives

3.1 To ensure that staff are appropriately advised of the action to be taken on scene.

3.2 To improve communication between LAS staff and professional colleagues

3.3 To help ensure that all patients who are conveyed by the LAS receive optimum care during their journey based upon their clinical condition, safeguarding the interests of both patient and staff

3.4 To help ensure that all patients attended by the LAS are offered referral or conveyance to a destination most suited to their clinical needs.

3.5 To ensure that the best use of Appropriate Care Pathways, e.g. Falls Services etc. and referral to GPs is considered where appropriate.

3.6 To minimise risks that can occur whilst on scene.

3.7 To ensure that adequate support is available for staff to call upon when working in vulnerable, unusual or challenging situations.

3.8 To provide clarity for both LAS and hospital staff of their role in the handover

of a patient, ensuring the provision of seamless patient care.

3.9 To ensure the patient is handed over in a safe and timely manner within prescribed time limits.

3.10 To help ensure that patients who are not conveyed for any reason are offered appropriate care and advice based upon their clinical needs, safeguarding the interests of both patient and staff.

3.11 To identify when responsibility for the patient transfers from the LAS to another responsible person or agency.

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

4. Responsibilities

4.1 Quality Governance Committee

The Quality Governance Committee provides assurance to the Trust Board on clinical, corporate, information governance and compliance matters ensuring high quality care to patients. It will also seek assurance from within the organisation that patient safety is being managed effectively and that effective processes are in place to manage and monitor hygiene/ infection control and safeguarding.

4.2 The Clinical Safety and Standards Committee (CSSC)

CSSC oversees the arrangements within the Trust for managing clinical safety and quality, clinical governance and clinical risk, as well as reviewing evidence and outcomes and developing or improving clinical practice. The Clinical Audit and Research Unit (CARU) provide evidence of the standard and quality of care provided to patients. Audit evidence is used for external reporting against Clinical Performance Indicators and Department of Health Ambulance Clinical Quality Indicators. CSSC has particular responsibility for ensuring the provision of high quality clinical care within the LAS, and managing the risks associated with that. CSSSC works closely with the Risk Compliance and Assurance Group to ensure that the management of all significant risks is monitored through one or other of the committees. The committee will have delegated responsibility for a number of the CQC regulation outcomes.

4.3 Chief Executive

The Chief Executive, as the Accountable Officer, has overall accountability for having a robust risk management system in place and an effective system of internal control, which is embedded within the Trust. The Chief Executive has delegated day to day responsibility for all aspects of risk management to nominated Executive Directors for their respective areas in line with the Risk Management Policy (TP/005).

4.4 Medical Director

The Medical Director has delegated responsibility for clinical governance, strategic development and implementation of the treatment and conveyance, (or discharge) of patients to a requisite care facility. The Medical Director will take the lead on aspects relating to patient safety in the strategic planning of the Trust and share with the Chief Quality Officer responsibility for the implementation of changes to clinical practice.

4.5 Chief Quality Officer

The Chief Quality Officer specifically leads on safeguarding and the need of disadvantaged and vulnerable groups and has responsibility as Director of Infection Prevention and Control.

4.6 Deputy Director of Operations – Control Services

The Deputy Director of Operations – Control Services has delegated responsibility for managing Control Services.

4.7 Deputy Director of Operations – Sector Services

The Deputy Director of Operations – Sector Services have responsibility for the day to day delivery of staff and vehicles to allow the treatment and conveyance, (or discharge) of patients to an appropriate care facility.

4.8 Clinical / Operational Staff

All Operational Staff irrespective of rank / role or grade are responsible for the day to day delivery of the treatment and conveyance, (or discharge) of patients to an appropriate care facility.

Clinical / Operational Staff responsibilities are fully set out within TP/003 (Statement of Duties to Patients). The principle responsibilities of Clinical/ Operational Staff are:

- Always work within LAS Trust policies and procedures.
- 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.
- Provide clinical leadership by assuming primacy of care 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) to a more senior clinician in attendance, if skills are required beyond their scope of practice.
- Keep clear, accurate and up to date patient records which report the relevant clinical findings, decisions made, and all treatment administered to the patient.

- Maintain and improve their professional knowledge, skills and competence through ongoing professional development taking account of professional guidance where appropriate.

- Observe the professional principles of integrity, honesty and patient confidentiality.

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

- 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.

Clinical/ Operational staff should undertake their assessment and management of patients in line with the UK Ambulance Services Clinical Practice Guidelines (current at the time of assessment and treatment), their level of training, clinical grade and if applicable, their Regulatory Body's code of professional conduct.

4.9 All Staff

It is the responsibility of **all staff** to identify and reduce risk to the lowest possible level and to report incidents to the appropriate manager, as detailed in HS011 (Incident Reporting Procedure). Employees also have a responsibility to cooperate with managers and to contribute to the process of identifying, managing and reducing risks as per TP005 Risk Management Policy.

Clinical / Operational Staff responsibilities are fully set out within TP/003 (Statement of Duties to Patients). The principle responsibilities of Clinical**/** Operational Staff are:

- Always work within LAS Trust policies and procedures.

- Recognise and work within the limits of their professional competence and in a safe and skilled manner.

-

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

- Maintain and improve their professional knowledge, skills and competence through on going professional development.

- Observe the professional principles of integrity, honesty and patient confidentiality.

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

5. Definitions

5.1 Conveyance

The definition of 'conveyance' for the purposes of this policy is based upon the following:

> 'The transfer of patients, medical and clinical personnel, equipment and associated records, as appropriate including from one healthcare facility to another as well as the initial journey from the scene.'

NHS Litigation Authority
Risk Management Standards for Ambulance Services

5.2 Patient Groups

For the purpose of this document patients are defined in the following groups: (Table - next page).

Patient Group	Definition*	Conveyance Requirements (transfer, medical/clinical personnel, equipment, associated records)
Adults	Age 18 and over.	
Paediatric Patients	Age under 18.	There are a number of facilities in London that do not accept patients under the age of 16. The Clinical Hub has up to date details of which Emergency Departments do not accept paediatric patients. Specific guidance exists for non-conveyed paediatric patients under 5 years of age.
Patients conveyed direct to a Primary Angioplasty facility / High Risk ACS / Arrhythmia Centre	This patient group is defined as having ECG evidence indicative of an acute myocardial infarction / Acute Coronary Syndrome or Arrhythmia	These patient groups are conveyed direct to a facility, that if required, can perform primary angioplasty / Acute Coronary Syndrome / Arrhythmia management.
Major Trauma	These patients are defined by triggering the Major Trauma Decision Triage Tool.	This patient group are patients conveyed directly to a Major Trauma Centre. This group may include London Air Ambulance or other Prehospital critical care teams and may also include transfer to an aircraft where the patient is to be air lifted.
Hyperacute Stoke	This group of patients is defined by current UK Ambulance Services Clinical Practice Guidelines And by LAS Medical Directorate Bulletins relating to stroke pathways	This patient group are patients conveyed direct to a Hyper Acute Stoke Unit. This is set out in current UK Ambulance Services Clinical Practice Guidelines and OP 59 Stroke Care Policy
Obstetrics	This group of patients is defined by current UK Ambulance Services Clinical Practice Guidelines obstetrics sections.	This patient group are patients conveyed direct to obstetrics facility. This is set out in current UK Ambulance Services Clinical Practice Guidelines and OP/ 035 Obstetrics Care Policy
Minor Injury Units/Walk in Centres/Urgent Care Centres and Appropriate Care Pathways	These patient groups are patients who are conveyed to Minor Injury Unit & Walk in Centres.	Section 16 The pathways for these units and the patients they accept are listed on The Pulse on the Complex home page.
Referred to another Health Care Professional	This patient group are patients who are not conveyed to a medical facility but referred to another healthcare professional for onward assessment, treatment and	Section 16

	care.	

**It should be noted that these definitions are for guidance in relation to this policy and definitions may vary for other policies and procedure.*

6. Documentation

The documentation to be completed for each episode of patient care is covered in detail in the Patient Report Form (LA4) User Guide.

This guide details the process for documenting all treatment provided, what documentation must be left with the patient, or accompany them when being conveyed to a treatment centre etc. in various circumstances.

7. Guidelines

7.1 Local Guidelines

Consent for examination and treatment must be gained for any patient treated by a member of LAS staff. Detailed guidance on consent to examination and treatment, and also on refusal to examination, treatment or transport is dealt with in OP/031 Policy for Consent to Examination or Treatment.

7.2. Management of Deviation from National Guidelines

If any deviation from accepted national clinical guidelines for the treatment of a patient is being considered, the detailed advice in OP/040 (Policy Advising Staff where Deviation from Guidelines is Considered) must be used. Staff should be aware of their level of education and experience and the potential need for further clinical advice in such situations.

8. Assessment, Diagnosis and Treatment Regimes

The process of assessment, diagnosis and treatment regimes should be carried out according to the current UK Ambulance Services Clinical Practice Guidelines, clinical training and professional scope of practice. Sections 9 to 16 set out the guidelines and specific actions to be taken when conveying a patient.

The type of information that needs to be given to the patient by the ambulance clinician will vary depending on circumstances and urgency, and should be based on the description and method of treatment, transport and on-going care. Taking into account mental capacity and age/ developmental stage, the Clinician should inform the patient of possible complications and side-effects and treatment options. This is set out in the Policy for Consent to Examination or Treatment

OP/031.

9. Crew Actions En-route and At Scene

9.1 Actions on Notification of Locality Information

If crews are alerted to a locality information flag via the mobile data terminal (MDT), they should normally contact the Emergency Operations Centre (EOC) to obtain further information from the Clinical Hub. In the event of a time-critical scenario, crews are to contact the Clinical Hub by calling priority on PD09, to obtain detailed information that may influence patient treatment (for example the existence of a DNA-CPR order).

In the event of a locality flag detailing high risk address information, crews should undertake a dynamic risk assessment to attempt to determine if it may be safe to proceed without the police. If after undertaking a dynamic risk assessment, it is believed that it is not safe to proceed without the police, this decision and the information used to inform that decision must be documented on the PRF, and staff should also ask for this to be recorded on the EOC Log.

9.2 Initial Actions on Scene

On arrival at the call location, the MDT should be updated. The time of arrival at the patient must also be recorded when completing the PRF.

Ambulance staff arriving at the location given via the MDT, but unable to locate the patient must contact EOC with this information and commence an ‘area search’. As a minimum the “area search” will mean that the crew exit their vehicle and physically search the area where the patient is thought to be. This area will be defined by the information received via the MDT / EOC / the “caller” / Bystanders etc. Staff are required to call EOC on their normal operating channel and request a read back of the FULL message. The crew will also attempt to make contact with the occupants of the premises where the patient is thought to be, and / or the original person who called “999”. During the area search, EOC will attempt to make contact with the caller to confirm the location. The LAS has a responsibility to take all reasonable steps to locate the patient. If, despite all efforts, the patient is not found, EOC must record on the Call Log ‘area search, no trace’ along with a record of attempts to contact the origin number and the resulting outcome. Ambulance staff must record ‘area search no trace’ (code 9013) on the PRF. The actions described above are a guide to the minimum actions required, any further action(s) taken by the crew / EOC will depend upon local circumstances.

When attending an emergency call, the minimum equipment to be taken to scene is an oxygen bag and an AED. Other equipment such as the primary response bag, collars, suction, paramedic bag etc. should be taken based on a dynamic assessment of the call details.

Those persons working on MRUs/CRUs will need to adapt the equipment taken to scene due to the way in which equipment is packaged and carried on the MRU/ CRU. A dynamic assessment of the call details will determine what other equipment is taken into the call.

Staff need to remember that when responding to patients in clinical environments such as GP Surgeries, Walk In Centres, Minor Injuries Units etc. there will not necessarily be resuscitation equipment or, or other equipment carried by LAS staff to hand, or clinical staff on site that can use such equipment.
Staff must bear in mind that they will need to explain why equipment was / was not initially taken to the scene.

If a patient is being transferred from a place of care and the patient is not ready the following should be noted:

If the delay is expected to exceed 15 minutes then EOC must be informed immediately and the crew should remain in contact with EOC. The final decision on whether ambulance staff should be re-deployed is the responsibility of the EOC Watch Manager. Effective liaison between ambulance staff and EOC is essential.

9.3 Forced Entry by Ambulance Staff

In the instance of ambulance staff being unable to gain access to a property they should contact EOC to confirm the address and that all relevant information has been received. If it is obvious that there is somebody in the premises that requires urgent assistance then the crew need not wait for further permission from EOC before effecting forced entry to the location. Examples would be where the crew can see the patient lying unresponsive on the floor with signs of blood loss evident, or a patient lying unresponsive, or presumed to be in cardiac or respiratory arrest.

<u>Action to be taken by EOC</u>

Before authorising a crew to make a forced entry into a private property, EOC should carry out the following checks:

- Listen to the tape recording and confirm that the crew have identified the correct address
- Ring the telephone number provided for that address or the caller/ informant
- Contact the police and request assistance, advising a possible ‘collapse behind locked doors’
- Ask the crew to establish from neighbours, relevant information about the

occupant and the location of spare keys to the property if known

- Once EOC are satisfied that there is likely to be a person in the premises that requires *urgent* medical help, permission may be granted to the crew to make a forced entry, if police are not in attendance.

- Where possible the patient should be seen or heard to be in distress before an entry is forced and their consent should be sought where possible. This does not apply in cases where the patient is unresponsive.

Staff should carry out a dynamic risk assessment, balancing the need for a fast entry, with their safety. Following this assessment, an entry with the minimum amount of damage and minimum personal risk may be attempted.

In the instance of a forced entry it is critical that EOC is made aware as soon as possible. EOC staff will advise the police and unless the patient's condition is deteriorating quickly, the crew should remain on scene until arrival of the police.

Where the patient's condition is time critical and requires immediate removal, an attempt should be made to secure the premises in the best way possible and to leave it looking visibly secure. Depending on the circumstances it may be appropriate to ask a responsible person to look after the premises until the police arrive.

Any forced entry in to a property should be documented on the PRF including the reasons for doing so and the efforts made to secure the property before departure.

9.4 Safety on Scene & Staff Welfare

When on scene it is paramount that ambulance staff first protect themselves, their colleagues, the patient and any other persons on scene. Once ambulance staff arrive at an incident, there may be instances where further Personal Protective Equipment (PPE) may be required. If the scene is for any reason considered unsafe, staff should initially withdraw and immediately inform EOC.

Close liaison must be maintained at all times with other emergency services and, where appropriate, the senior safety officer or other responsible person on scene.

If, on arrival at scene, staff discover the call falls within the remit of the Road Traffic Act (this includes incidents such as falling from, or falling on a bus) they should inform EOC as soon as possible and where injury has occurred, request the attendance of police. If the police have not arrived before conveying the patient, the crew should inform EOC of this fact and the hospital to which they are conveying the patient.

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

which may affect the patient, the situation or the outcome in any way.

All ambulance staff must proceed with caution when confronted with potentially violent situations and must place their own safety first. If faced with threatening behaviour, ambulance staff should make all efforts to diffuse the situation remaining calm, respectful and polite at all times. Further guidance is available in the Violence Avoidance and Reduction Procedure (HS012).

If unsuccessful and the situation persists or escalates, staff should withdraw and request police assistance via EOC. Form LA277 must be completed. Refer to the Incident Reporting Procedure HS011 for guidance.

If ambulance staff subsequently feel they need further support or assistance once the incident is complete, they should contact EOC who will contact the appropriate manager. Any untoward incidents should be reported using Datixweb or the incident reporting form (LA52). Further guidance is available in the Incident Reporting Procedure (HS011) – available on the Pulse.

9.5 Patient Communication and Interaction

Due to the diverse population that the LAS serves, it is likely that ambulance staff will come into contact with patients where there are communication difficulties. These difficulties may cause the patient further distress and anxiety, thus limiting patient assessment. Support and guidance is provided for ambulance staff through the LAS Multi Lingual Emergency Phrase Book and Pre-Hospital Communication Guide. Operational ambulance staff have access to Language Line via Airwave hand-portable radios. The number can be accessed in the handset phonebook. Communication difficulties may come in one of many guises and LAS staff must make every effort to ensure that the patient is involved in all decisions surrounding aspects of their care.

LAS staff are constantly in contact with patients from different cultures. Staff must treat all patients equally, affording them courtesy, respect and politeness at all times. Under no circumstances should a patient be treated less favourably than another on any grounds.

As representatives of the LAS, ambulance staff should ensure that they conduct themselves in a manner that reflects both their own and the Service's professional standing. A professional approach includes:

- Wearing LAS uniform in accordance with the Dress Code for Uniformed Staff
- Body language that imparts sympathy and understanding,
- Interpersonal and clinical skills that allow ambulance staff to assess each patient in a calm, confident and methodical manner

Staff should be aware that their actions on scene may be witnessed by third parties

who may feel that an action, inaction or statement is inappropriate for the circumstances. Staff should make every effort to explain their actions to those who have reasonable cause or grounds to request such information.

A patient's behaviour may at times appear unreasonable, but despite this staff should not be drawn into arguments. Any problems should be documented on the PRF and referred to a line manager, if required.

Disagreements between LAS staff or with other Health Care Professionals must never take place in public places or in view or hearing of the patient or general public.

9.6 Patient Welfare

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

When the patient is being conveyed to a home address which is found to be unhealthy or unsafe it should be reported to EOC as soon as possible before leaving the premises. A consensus should be reached between clinical staff on scene and the Clinical Hub on what appropriate action to take, e.g., locally agreed access pathways to social services and where cases of abuse or vulnerability are suspected, implementation of TP/018 or TP/019.

Wherever possible the patient's property should be left with the patient, or a person accompanying the patient (where it may reasonably be assumed that such a person will be acting in the best interests of the patient). There may, however, be some circumstances where the patient or any other person is unable to take responsibility for the patient's property. In these instances the items should be taken to hospital with the patient, using the designated patient property bag. The bag should be sealed in the presence of the patient, the details completed and a record of the bag number made on the PRF. The bag should be passed to hospital staff at the handover of care; the tear-off strip should be attached to the copy of the PRF handed to the hospital, or given to the patient, if necessary secured around the patient's wrist.

If, however, the property is bulky and not easily transportable, for example a bicycle, attempts should be made for it to be secured at scene and only as a last resort stored as securely as possible in the vehicle and conveyed with the patient. Arrangements should be made at the hospital site to secure the item, and for the patient to be notified accordingly either by LAS staff or by hospital staff. Any action should be documented on the PRF.

Ambulance staff should always check the ambulance for patient property before leaving the receiving unit.

The Patient Experiences Department will host enquiries relating to patient property. Where information is not documented on the PRF, the matter will be referred to the relevant Group Station management team for local resolution. Local managers

should be aware of the requirement to advise an enquirer of their right to make a formal complaint and/or a compensatory claim. In this event the matter should be referred to the appropriate department.

If it is brought to the attention of ambulance staff that a patient in need of conveyance has sole responsibility for an animal, reasonable measures should be taken to ensure that the animal is subsequently cared for.

If the patient is in a public place when receiving emergency care and has an animal with them, ambulance staff should ascertain whether there is an appropriate person on scene to take short term responsibility of the animal. If not EOC should be informed and asked to contact the police. As an absolute last resort and at the discretion of staff the animal may be conveyed with the patient. Guide dogs must be conveyed as a matter of course and dogs should be placed in the front of the ambulance on passenger-side floor. A lead must be securely attached to the dog and an anchor point, to prevent the animal moving during transport.

If the patient is in their own environment and responsible person (i.e. neighbour) is available, it may be appropriate to ask them to ensure the animal is looked after. If this is not the case, then ambulance staff should contact EOC who will inform the police or appropriate services.

Used equipment, soiled dressings and/ or sharps should NOT be left on scene. If waste is generated at any time whilst attending a patient, it must be disposed of according to service policy and in accordance with the LAS Infection Control Manual.

All patient medication must accompany the patient, using the green pharmacy bag provided by the LAS, to their destination. Prescription lists should not routinely be taken in place of actual medicines. Patient details must be clearly written on the front of the bag in the box provided or a hospital label with these details attached. This should be documented on the PRF and handed to the receiving hospital staff.

In the case of a patient being transported to hospital from a nursing home, medicines should be requested from the Registered Nurse on duty. If it is not possible to take all the medicines, a copy of an up-to-date prescription list should be requested.

9.7 Patient Protection

Everyone has a responsibility to report a suspicion of criminal offence. Ambulance staff, in common with other NHS staff, also have a duty of confidentiality towards their patients. These priorities need to be balanced to ensure that appropriate medical care is provided for all patients whilst alerting police to a crime or crime scene.

If ambulance staff believe or suspect that their patient is involved in a crime they must continue to treat that patient and, if necessary, convey to hospital. Staff must immediately inform EOC, or advise hospital staff, to inform the police of their suspicions or evidence. In any event, EOC must always be informed so that the call

log can be updated to reflect this information.

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

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

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

If staff suspect an adult is being abused, TP/019 Suspected Abuse of Vulnerable Adults Procedure must be implemented. Additional guidance is available in the current UK Ambulance Services Clinical Practice Guidelines.

The situation must be documented on the PRF and the appropriate Child Protection Report Form (LA279) or Protection for Vulnerable Adult Form (LA280) must be completed either by the crew or through the Emergency Bed Service (EBS). A registered clinician in the receiving Emergency Department must be notified at hand over of the completion of a referral form and the circumstances surrounding the patient. The receiving clinician's name and designation must be recorded on the PRF.

If the victim of suspected abuse is the patient and they are not conveyed, or the victim is not the patient at the location, ambulance staff must complete the relevant form (LA279/LA280). Ambulance staff should be made unavailable so they can complete the reporting procedure as per OP/044 (Vehicle off the Road Procedure).

Injuries or illness related to the workplace are covered by specific Health and Safety legislation. This is normally reported to the Health & Safety Executive (HSE) under RIDDOR guidance. However ambulance attendance to a workplace for life changing, life threatening or fatal accidents should be reported to the police as soon as possible via EOC. The police may need to instigate criminal investigation and/or notify HSE investigators. Where possible bystanders/ workers etc. should be advised not to dismantle or tamper with machinery involved in an incident except to make it safe as it may be subject to investigation. This section also applies to members of the public or non-employees in a workplace setting. The following are examples of workplace incidents that should be reported to the police at the time of the accident:

- Fatal accidents
- Amputation and/or multiple trauma
- Loss of sight or serious eye injury
- Injury resulting from an electric shock or electrical burn leading to

unconsciousness, or requiring resuscitation or predicted admission to hospital for more than 24 hours

- Serious illness and/or unconsciousness caused by asphyxia or exposure to harmful toxin, chemical, biological or radiological substance.
- Any other injury deemed to be serious and necessitating prolonged hospital care/intervention.

There are frequent requests for observers to accompany ambulance crews on Emergency or Patient Transport Service (PTS) vehicles. Approval for observers on either Emergency or PTS vehicles can only be authorised once the procedures detailed in TP/014 (Procedure for Ambulance Observers) have been followed.

- When such arrangements have been approved, the observer, regardless of their status, qualifications and training must not become involved in the care and treatment of patients unless specifically requested to do so in an emergency by ambulance staff. Observers must not bring their own clinical equipment or drugs when undertaking an Observer shift.

- Observers should be clearly identified by wearing an LAS hi-visibility jacket marked 'Observer'.

10. Appropriate Clinical Care of Patients

All staff must act within their own professional boundaries recognising when to, assume responsibility from a less experienced or qualified colleague and when to hand over responsibility to another senior professional colleague, as per TP/003 (Statement of Duties to Patients). The highest clinical grade on scene takes overall responsibility for patient care. This however can be superseded by the arrival of further assistance i.e. a paramedic arriving after an Emergency Medical Technician crew or a pre-hospital physician arriving to assist a paramedic. Careful consideration must be taken when delegating clinical responsibility to a lesser qualified colleague – clinical primacy in the pre-hospital phase of care is retained regardless of delegation. This clinical primacy is maintained until hospital handover, appropriate referral, leaving the patient in the care of a responsible person (refer to Appendix 1) or valid refusal of assistance. If multiple members of staff are on scene of the same clinical grade – the first person engaging the patient in clinical care assumes responsibility. This can be delegated if required, following a clear handover and acceptance of professional responsibilities and roles.

Staff must ensure that all clinical assessments are undertaken in accordance with their training. These are detailed in the current UK Ambulance Services Clinical Practice Guidelines, which are provided on a personal issue basis to staff. Consequently, staff with queries on any aspect of this material are encouraged to seek assistance from their Team Leader, or Clinical Tutor.

The LAS Patient Report Form (LA4) provides a grid to accommodate two sets of observations. Additional observations and comments can be added in the free text

box. Further supporting information can be obtained from the Patient Report Form User Guide, available on the Pulse.

Early consideration should be given to further specialist resources required at scene. Requests should be made, where appropriate, for Advanced Paramedic Practitioners, London's Air Ambulance, BASICS or clinical advice via EOC.

Having addressed all matters of initial scene safety, attending staff must make a full assessment of the patient before determining where the patient will be transported to. The extent of clinical assessment required will vary dependent on the patient's condition and the skill level of the clinician, and will at least comprise of a primary survey, along with due consideration to the mechanism of injury where indicated, and will be extended as indicated to include a secondary survey, review of systems and comprehensive physical examination following the medical model. However, it is recognised that the detection of any time critical problems may require the assessment to be aborted, enabling the crew to commence rapid transportation with appropriate treatment en-route. Equally, situations involving patient entrapments or delays in removal from scene may require the summoning of additional clinical resources and/or other emergency services to the incident. Subsequent management of the patient will include the continual reassessment and correction of any primary survey problems, together with a comprehensive secondary survey where circumstances permit.

Where further assessment or treatment at a centre of care is required, the method of transport will be determined by the lead clinician. The destination and mode of transport of the patient must be determined based upon clinical need and the facilities available at local emergency and urgent care facilities.. This decision should take into account the wishes of the patient (or a relative) wherever appropriate. The Trust recognises that there will be cases where following a comprehensive assessment conveyance to a centre of care by Emergency Ambulance is not required. In such cases, clinicians should explore alternative methods of transport, ensuring continuity of care by providing a copy of the PRF to the patient, and completing a clinician-to-clinician handover if required by the Appropriate Care Pathway/ destination unit being utilised.

If the lead clinician determines following further assessment that conveyance by Emergency Ambulance is not required it is acceptable to refuse transport by Emergency Ambulance. Alternative transport arrangements such as private transport, taxis etc… must be discussed with the patient and their relatives or carers as appropriate, taking into account any potential clinical risks and the condition of the patient..

Patients receiving on-going investigation or treatment for a specific condition may be conveyed to the hospital where their treatment is provided if appropriate, on the provision that a more serious or life-threatening condition does not take precedence. In all such cases, staff must ensure that the best interests of the patient are assured and no significant clinical risk arises. The PRF should be completed in accordance with the PRF User Guide. Any reason for deviation away from the local Emergency

Department (ED) should be documented on the PRF (i.e. patient presenting with sickle cell crisis being transported to a specialist centre where the patient treated).

Advice can be obtained from the Clinical Support Desk in determining the most appropriate patient destination.

Patients attended as the result of emergency calls may be conveyed to the nearest appropriate Emergency Department. However there are exceptions to this:

- The nearest/local Emergency Department does not receive a certain category of patient, i.e. paediatrics or trauma. These patients must be conveyed to the next appropriate Emergency Department.
- The condition of the patient suggests that rapid access to specialist treatment will require that they be directly conveyed to a hospital providing that speciality, i.e. Major Trauma Centre, Hyper Acute Stroke Unit or Heart Attack Centre.
- Maternity patients should be managed according to current JRCALC guidance and where appropriate, local arrangements.
- Patients whose condition justifies the use of an alternative referral pathway, which could include conveyance to a minor injuries unit, Urgent Care Centre, Walk in Centre or non-conveyance and referral to a pathway available in the community (for example arranging for a district nurse or other primary healthcare practitioner to visit).
- An alternative transport option has been arranged.

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 clinically appropriate and safe and not override that request unless first discussed with the HCP.

In cases where a HCP has requested transport to a specific destination, but on assessment by LAS staff it is determined that the patient requires transport to a specialist centre, the HCP should be contacted and advised (i.e. a GP assesses a patient experiencing chest pain, refers them to the nearest ED, but on LAS assessment a STEMI is diagnosed and the patient transported to a Heart Attack Centre).

10.1 Caring for Children

A child is defined in the following section as a person under 18 years of age. This is consistent with The Children Act 1989.

It is good practice for a parent/guardian to accompany a child to hospital and ambulance staff should make every effort to ensure that this happens. When this is not possible, either a teacher or other responsible adult can accompany the patient. If this is not possible the patient may travel unaccompanied with the ambulance staff. If the child is travelling unaccompanied EOC must be informed and document this on the call log. Staff must obtain as much information about the patient as possible including relevant medical history to ensure a full hand over on arrival at the hospital. Emphasis must be placed at clinical handover to the hospital clinician that the child is unaccompanied and any contact details of the parent or guardian should be handed over. This should be clearly documented with a name and signature on the PRF.

Before examining or treating a child ambulance staff must gain consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Children under 16 years of age have the right to provide independent consent proportionate to their competence (although their parents will ideally be involved). In cases where children do not have the capacity to consent for themselves, parents or someone with parental responsibility must give consent on the child's behalf. If the situation is deemed life threatening and the parent/ person with parental responsibility is not available the attending ambulance crew must act in the patient's best interest. If a competent child consents to treatment, a parent cannot override that consent. Legally, if a competent child refuses treatment a parent/ person with parental responsibility may override that decision – see also OP/031 Policy for Consent to Examination or Treatment for more information.

If the removal of a patient to hospital will result in a child being left unsupervised, ambulance staff must either convey the child/ children or contact EOC to arrange for the police to attend and assume responsibility. This action should not delay the patient's conveyance to hospital. If the patient's condition is serious and children are to be left alone, then the urgency for the police attendance must be indicated.

There is no minimum age at which a child may be left unsupervised. Legally, no offence is committed until the child comes to harm, at which point the responsible adult or parent can be prosecuted for failing to ensure their safety. As a guide, the following points should be considered

- If a child is under fifteen years, staff should make arrangements as per Appendix 1 of TP/003 – Statement of Duties to Patients. Although the child is not a patient, the principles contained in that appendix hold for this type of situation.
- Children between fifteen and eighteen years may be temporarily left alone

if staff are confident of the child's ability to care for themselves. If a child is left at home the receiving clinician must be notified at hand over and the occurrence documented on the PRF and the EOC log.

If an unrelated adult (for example a neighbour) offers to take responsibility for the child and the patient or person with parental responsibility is not able to approve that arrangement, then ambulance staff must inform EOC to request police attendance.

11. Working with the Police

This section details the London Ambulance Service (LAS) Procedure as agreed between the LAS and the Metropolitan Police Service (MPS) to cover the following areas:

- Appropriate transportation of persons to hospital
- Section 136 of the Mental Health Act
- Emergency treatment and transport of persons without capacity who withhold consent

It is recognised that working relationships between the LAS and MPS at the front line are generally extremely good. This section aims to formalise these working relationships and clarify roles and responsibilities.

Any action taken by the LAS and MPS must be:

- Legal
- Proportionate
- Accountable
- Necessary
- Based on best available information

Actions must be in accordance with the Human Rights Act and other legislation, specifically the Health and Safety at Work etc Act 1974, the Mental Capacity Act 2005 and all other relevant statutory provisions and recognised codes of practice.

11.1 Appropriate transportation of patients following police contact

In general the majority of such patients requiring treatment following assessment by an ambulance crew will be taken to hospital by ambulance. However, there may be exceptional occasions when ambulance transport is not appropriate, i.e. if there is a risk of the person harming themselves, a member of the ambulance crew or any other person and/ or the person is so violent or dangerous that the attendance of a police officer or officers in the ambulance will not adequately address the risk. In reaching this decision, which must be recorded, the ambulance crew should consider the following:

- The person's behaviour at the time
- Any relevant history

- Any risks presented to the person, LAS crew or others

Where practicable, police officers and other professionals on scene, as well as the person and / or carers should be involved in this risk assessment.

If police are not already present, and the ambulance crew determine that such a risk exists, consideration will be given to asking for police to attend the scene. In these cases it will be the responsibility of a member of the ambulance crew to provide the police officer(s) with a briefing of the circumstances and the identified risk factors, and precisely what assistance is requested.

Where the person is under arrest and requires medical treatment at hospital he will normally be conveyed to hospital in an ambulance. At least one police officer will accompany the person in the ambulance at all times whilst he remains under arrest. In these cases the role of the police will be to prevent crime and/or a breach of the peace and to prevent the person's escape from lawful custody and police officers may use such force as is reasonable, necessary and proportionate to those ends.

Where it is agreed between the ambulance crew and the police officer(s) that, notwithstanding the person's need for medical treatment at hospital, it is necessary and proportionate by reason of the person's behaviour to convey the person to hospital in a police vehicle this course of action will be followed, with the following conditions:

1. In all cases the most clinically qualified member of the ambulance crew must accompany the person in the police vehicle in order to maintain constant observation. If the injuries / illness of the patient are such that the aggression of the patient is such that sedation of the patient may be required, then staff must seek further advice from the Clinical Hub. Sedation may be offered via the dispatch to scene of an Advanced Paramedic Practitioner, or other suitably qualified clinical resource.

2. Equipment to undertake basic life support must be in the police vehicle with the ambulance clinician. As a minimum, this needs to include oxygen, bag-valve-mask and defibrillator.

3. The ambulance will closely follow the police vehicle to the hospital/ other destination. The need for the use of blue lights and audible warning devices must be discussed between the police and the ambulance staff prior to settting off for the destination.

Where the person is under arrest and objects to being taken to hospital **and** where the ambulance crew advises that the requirement for medical treatment is not urgent the person may be taken directly to a designated police station in a police vehicle. If the person does not have mental capacity, the crew must act in the best interests of the patient (refer OP/ 031 – Policy for Consent to Examination or Treatment).

Where papers have been completed under sections 2, 3 or 4 of the Mental Health Act 1983 following an assessment on private premises, the patient will normally be conveyed by ambulance to the hospital named in the application. Where the Approved Social Worker/ Approved Mental Health Professional so requests one or more police officers may accompany the patient in the ambulance. In these cases the role of the police will be to ensure the transportation to hospital is effected, prevent crime and/or a breach of the peace and to prevent the patient's escape from lawful custody and police officers may use such force as is reasonable, necessary and proportionate to those ends. The section papers should accompany the patient, but in all cases be with the patient at the patient's destination.

Where papers have been completed under sections 2, 3 or 4 of the Mental Health Act (1983) following an assessment on private premises **and** the Approved Social Worker/ Approved Mental Health Professional so requests, **and** it is agreed between the ambulance crew and the police officer(s) that the person is so violent or dangerous that it is necessary and proportionate to convey the patient to hospital in a police vehicle this course of action will be followed, with the following conditions:

1. In all cases a member of the ambulance crew will accompany the person in the police vehicle in order to maintain constant observation. If the injuries / illness of the patient are such that the aggression of the patient is such that sedation of the patient may be required, then staff must seek further advice from the Clinical Hub. Sedation may be offered via the dispatch to scene of an Advanced Paramedic Practitioner, or other suitably qualified clinical resource.

2. Equipment to undertake basic life support must be in the police vehicle with the ambulance clinician. As a minimum, this needs to include oxygen, bag-valve-mask and defibrillator.

3. The ambulance will closely follow the police vehicle to the hospital/ other destination. The need for the use of blue lights and audible warning devices must be discussed between the police and the ambulance staff prior to settting off for the destination.

Where the person is not under arrest nor detained under the Mental Health Act as above, a police vehicle **cannot** be used to transport the person. Consideration will be given by the ambulance crew and police as to whether the person is so violent or dangerous that it is proportionate and necessary for police to assist the ambulance crew either by a police officer(s) travelling in the ambulance or by a police vehicle accompanying the ambulance to hospital. In these cases the role of police will be to prevent crime and/or a breach of the peace and police officers may use such force as is reasonable, necessary and proportionate to those ends.

A police vehicle will **not** be used to carry out inter-hospital transfers.

Where it is necessary for a police officer to use force during the transportation of a person to hospital he will record all relevant matters in an Evidential Report Book and a member of the ambulance crew will endorse the report.

11.2 Section 136 of the Mental Health Act

The LAS and MPS are committed to providing a safe, secure and supportive response to people undergoing a mental health crisis in a public place. It is recognised that such people may also have underlying medical conditions that require emergency hospital treatment. For this reason, it is considered appropriate wherever possible to convey by ambulance persons detained by a constable under Section 136 of the Mental Health Act. However, it is recognised that there will be occasions when it is not safe to transport in an ambulance, even with the assistance in the ambulance of a police officer or officers, and the person needs to be conveyed in a police vehicle supported by the crew of an LAS ambulance.

Section 136 of the Mental Health Act states:

‘If a Constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the Constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety…’

In every London Borough the police have agreed with mental health trusts a place of safety, which is not a police station. In some boroughs the agreed place of safety is a psychiatric reception unit; in others it is an Emergency Department.

Persons detained under Section 136 should, as a rule, be conveyed to a place of safety by ambulance, in recognition of:

- Their human rights
- Duty of care (both LAS and MPS)
- Respect for their dignity
- Public perception

The guiding principle is that, if there is a requirement for medical treatment for a physical injury or condition this outweighs the need for assessment under the Mental Health Act.

If the ambulance crew decide that the person requires medical treatment at hospital (other than a psychiatric hospital), they will determine the destination hospital (usually the nearest Emergency Department) in accordance with LAS procedures. The police officer(s) will retain custody of the person and accompany the person to hospital in the ambulance. They may use such force as is reasonable, necessary and proportionate to prevent crime and/or breach of the peace and to prevent escape from lawful custody.

The MPS policy is that, where acute behavioural disturbance is suspected, the person should be treated as in need of emergency medical treatment, because of the known risk of sudden collapse and death in such people, and should be conveyed to the Emergency Department by ambulance. The main features of this extreme state are a period of agitation, excitability, perhaps paranoia, coupled with great strength, aggression and non-pain compliance. Officers are unlikely to know whether the person has a cardiovascular problem or a psychiatric disorder, or indeed whether the person is abusing drugs. All these factors may increase the risk of death.

Where the ambulance crew decide that medical treatment at hospital for a physical injury or condition is **not** required, the person will be taken by ambulance to the place of safety designated by the local section 136 protocol.

However, there may be occasions when ambulance transport is not appropriate, i.e. if there is a risk of the person harming themselves, a member of the ambulance crew or any other person and the person is so violent or dangerous that the attendance of a police officer or officers in the ambulance will not adequately address the risk. In reaching this decision, the ambulance crew should consider the following:

- The person's behaviour at the time
- Any relevant history
- Any risks presented to the person, LAS crew or others

Where practicable, police officers and other professionals on scene, as well as the person and/or carers should be involved in this risk assessment.

If it is agreed between the ambulance crew and the police officer(s) that it is necessary and proportionate by reason of the person's behaviour to convey the person to the designated place of safety in a police vehicle, this course of action will be followed, with the following conditions:

1. In all cases a member of the ambulance crew will accompany the person in the police vehicle in order to maintain constant observation

2. Equipment to undertake basic life support must be in the police vehicle with the ambulance clinician. As a minimum, this needs to include oxygen, bag-valve-mask and defibrillator.

3. The ambulance will closely follow the police vehicle to the hospital/ other destination.

The police officer(s) are responsible for a 'legal' handover under the Mental Health Act, in accordance with the local protocol. The ambulance crew are responsible for providing a clinical handover to the staff at the hospital or other place of safety. It is not expected that the ambulance crew will remain at the place of safety once they have handed over the person's clinical care.

11.3 Use of Restraint

There are a number of different types of restraint:

- Psychological restraint
    - Can include constantly telling someone not to so something or depriving individuals of equipment or possessions which enable them to do what they want to do (e.g. glasses, hearing aids, mobility aids etc.)
- Chemical Restraint
    - Is the use of medication for the purpose of alleviating or managing symptoms or behaviours associated with an underlying psychological condition. In the LAS this will only be undertaken by staff who have been specifically authorised and trained to administer the requisite medication using guidance approved by the LAS Medical Director
- Mechanical Restraint
    - Involves the use of equipment to restrict movement (e.g. arranging furniture to restrict movement, mechanical locks, blanketing etc.).
- Physical Restraint
    - One or more members of staff holding the person, moving the person, or blocking their movement to stop them leaving.
- Restraint may be used either (a) reactively i.e. in response to violence or to prevent harm or (b) proactively to support necessary treatment or where an assessment has indicated that an individual is likely to pose a risk to self or others.

The following is a general guidance to the use of restraint and the observation and assessment of a patient who is being restrained. For the full LAS guidance for the restraint of patients please refer to OP 076 Policy and Procedure on the Use of Restraint

No patient should be restrained in a prone position, due to the risk of positional asphyxia. Positional/ restraint asphyxia is defined as occurring when ‘the position of the body interferes with respiration, resulting in asphyxia (suffocation)’. Positional/ restraint asphyxia can occur extremely rapidly when a patient is in a position that interferes with inspiration and/ or expiration and cannot alter that position. This risk is magnified in patients who are handcuffed.

Owing to the risks of positional/ restraint asphyxia, the prone position must not be used during transportation. If restrained, the patient must receive close and continuous monitoring. As a minimum, level of consciousness (AVPU, heart rate, end-tidal CO_2, effort of breathing, SpO_2, ECG and blood pressure must be monitored. If it is not possible to monitor any of the vital signs listed, the reason must be clearly documented on the PRF.

Where it is necessary for a police officer to use force during the transportation of a person to hospital he will record all relevant matters in an Evidential Report Book and a member of the ambulance crew will endorse the report.

11.4 Emergency Treatment of Patients Without Capacity who Withhold Consent to Treatment.

If an adult is not capable of making his/her own health care decisions, based on an assessment of his/her capacity (see OP/031 Policy for Consent to Examination or Treatment), LAS staff will have to consider intervention against their wishes under the terms of section 5 of the Mental Capacity Act 2005. These terms apply when a decision is made to act in the best interests of a patient who has been assessed as lacking capacity at that moment.

Where the Mental Capacity Act is to be invoked LAS staff are aware that the reasons for its use are to be documented on the person's clinical record form (LA4). LAS staff will also have access to form LA5 as an assessment of capacity tool that will assist in making a decision whether to invoke treatment in the person's best interests. Whilst it would be good practice to involve carers, the urgent circumstances may not allow this to take place. It is also understood that the actions taken by either the LAS or Metropolitan Police under the Mental Capacity Act are limited to interventions which are deemed by the clinician to be in the patient's best interests and the least restrictive means of achieving the goal of care, this may include assessment, treatment and conveyance, be it either an Emergency Department or another centre of care.

Any intervention must also depend on a physical assessment, which considers the likelihood of the imminent risk to the person of loss of life or limb. If it is felt that, without immediate treatment, there would be a significant or irreversible deterioration in health, the LAS has a duty to intervene safely and provide care in the person's best interests.

In circumstances where the ambulance crew feel the person will physically resist efforts to take them to hospital, and the person is so violent or dangerous that police assistance is needed, they may request the police to attend to provide assistance or support in removal of the person by force if necessary. The ambulance crew will provide a full briefing to the police officers, including the results of their assessment of the person's capacity, and give a clear request of

the nature of the assistance required from the police.

The role of the police in supporting the LAS in these circumstances will be to prevent crime and/or a breach of the peace and, where requested by a member of the ambulance crew, to assist in restraining the person in order that he may be conveyed to hospital and/or treated as necessary in his best interests and police officers may use such force as is reasonable, necessary and proportionate to those ends.

The police officer will record the matter in an Evidential Report Book and a member of the ambulance crew will endorse the report to the effect that they believe the person lacks the mental capacity to refuse or consent to treatment, that urgent treatment is required to prevent loss of life and/or serious or irreversible deterioration in the person's condition, and that police assistance is requested to prevent crime and/or prevent a breach of the peace and/ or to enable the person to be conveyed to hospital and/or treated as necessary in his best interests.

12. Removal to Ambulance & Manual Handling

Patients must be removed from scene to the ambulance using the most expedient route and method available based upon their clinical needs. It is essential that staff constantly reassess the patient's condition to ensure the method of removal is compatible with minimising any risks for the patient.

Staff must ensure that all efforts are made to protect the privacy, confidentiality and dignity of their patients. These not only reflect the rights of patients as individuals, but treating all patients with courtesy and consideration significantly helps them to feel safe and secure. Similarly, attention given to the positioning and comfort of patients during the removal and subsequent journey only adds to enhance the overall patient experience.

A risk assessment should be undertaken prior to any manual handling activity. Early consideration should be given to the need for additional or specialist resources to assist with extrication as required.

For the purposes of mobility classification, patients conveyed by the LAS are categorised as one of the following:

Stretcher – patients who must be carried to and into the ambulance, and who are required to travel on the trolley bed.

Chair – patients who must either be carried to and into the ambulance, or who can walk to and into the ambulance with the assistance of two staff, and who may travel in a sitting position.

Walking – patients who require no assistance, or the assistance of one member of staff to walk to and step up into the ambulance, and may travel in a sitting position.

Staff must determine the mobility classification of emergency patients based upon their clinical assessment, and the requirements of current clinical protocols and guidelines. Once again, the potential risks for patient harm caused by inaccurate and inadvertent patient/staff actions cannot be overemphasised.

Patients with mobility aids should be allowed to use and take these with them if they so wish and if deemed appropriate by staff. Patients in wheelchairs must be transferred to a fixed seat or trolley bed once on board the ambulance, and if the wheelchair is to be taken it must be safely stowed. If the vehicle has the capability of securing a wheelchair with the patient restrained, this should be utilised if clinically appropriate.

Non-emergency patients who are required on clinical grounds to stay in their wheelchairs during conveyance will only be conveyed in an appropriate vehicle with floor clamps, and a safety harnesses used to secure the patient.

Should a patient continue to act against the advice given, EOC should be informed at the earliest opportunity and the details recorded on the PRF. This information should also be included in the handover to staff at the receiving destination. All efforts must be made to ensure that any potential clinical risks that are a result of the patient's actions contrary to advice are kept to a minimum.

Ambulance 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 the assistance of a second ambulance crew or other services should be sought.

Walking patients should use the hand rails provided to assist themselves into and out of the vehicle. Ambulance staff will need to give additional guidance if the person is injured, disabled, hard-of-hearing or has impaired sight.

Ambulance staff can request assistance from responsible personnel such as police officers, nursing and porter staff and members of the public, but they must give clear and concise instructions and not ask them 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 lifting aids supplied by the Service. If other lifting equipment is available on scene, for example, hoists, consideration should be given to allowing only the persons trained in use of the equipment to assist in the lift.

Ambulance staff called to attend patients in Care Homes are duty bound to fully examine, assess and treat appropriately. If it is necessary to lift the patient, staff should seek alternatives to manual handling such as hoist and slides if suitably qualified persons are present.

If patients in Care Homes are found to be uninjured the responsibility for lifting should be passed back to the Care Home staff.

13. En route to Destination

In order to give maximum protection to patients and escorts whilst on Service vehicles, every effort must be made to ensure that seat restraints are used. Patients and escorts who decline to wear seat restraints should have their attention drawn to the notice displayed. If they still decline, a reference to this must be recorded on the reverse of 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 the ambulance, where it is possible to do so, rests with the driver.

The attendant must travel in the back of the ambulance with the patient. 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. The person with clinical primacy must remain with the patient or suitably delegate care. Clinical primacy of care rests throughout with the most qualified member of the crew and cannot be delegated. HCPC registered paramedics cannot delegate primacy of care to an EMT or T/EAC and should ensure that this is taken into consideration when leaving patients in the care of less qualified staff.

The decision as to how many friends or relatives travel with the patient rests with the crew, and must be based upon both the patient's needs and the practicalities of the patient's treatment. When allowing escorts to travel with the patient, consider the following factors:

- Maximum loading on the vehicle, including patient and ambulance staff must not exceed the legal maximum for the vehicle.
- Escorts who are themselves distressed may have an adverse effect on the patient.
- Ambulance staff safety is paramount – escorts who appear drunk/ disorderly may compromise that safety. Equally, refusing an escort may aggravate the situation and will require careful judgement by the crew.
- If the patient is in cardiac arrest, or arrest is imminent, a relative/ close friend may benefit emotionally from witnessing that everything possible was being done, including active resuscitation. If the decision is taken not to convey the relative/ close friend with the patient, consideration should be given to arranging alternative transport.

If the attendant decides not to allow escorts, this message should be conveyed with sensitivity, tact and diplomacy.

Wherever possible the PRF should be completed whilst en-route to hospital. If this cannot be achieved then the PRF should be completed as soon as possible on arrival at hospital. In the event that a FRU has attended the call prior to an ambulance, a copy of the single responder patient handover record should be given to the crew conveying the patient so that it forms part of the overall patient record.

In some situations clinical care and handover takes priority over completion of the PRF, particularly where patients are time critical (i.e. major trauma, stroke and STEMI). Rapid transport to definitive care must not be delayed in order to complete a PRF on scene. In time-critical cases the PRF should be completed as soon as possible and then left with the receiving clinician to form part of the patient's record. It is unacceptable to delay the transport of any patient purely for the purpose of completing paperwork.

14. Pre Alert Call

The current UK Ambulance Services Clinical Practice Guidelines along with local guidelines provide advice as when to place a pre alert call. A pre alert should be placed to the receiving unit, via Airwave talk-group PD09.

The pre alert call should be structured using the CASMEET mnemonic:

Call Sign
Age of patient
Sex of patient
Mechanism or injury or Mode of Illness
Examination (AVPU/GCS, RR, HR, SpO2, BP etc.)
Estimated Time of Arrival
Treatment given

If undertaking a 'Critical' inter-hospital transfer, a pre alert call must be placed to notify the receiving unit that the patient is now on their way and an ETA provided.

The use of the pre alert call should not be based on the physical distance from the hospital but on the clinical condition of the patient.

When placing a pre alert call the crew should proceed to hospital under emergency conditions (blue lights).

15. Actions at Destination

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

A clinical hand over of the patient should be given to the Health Care Professional taking responsibility for that patient, using the PRF to provide structure and clarity of the information provided.

The patient's privacy must be maintained at all times. Patient handover should be undertaken discreetly, minimising any possibility that confidential patient information may be overheard.

Ambulance staff should also hand over any other relevant information regarding the patient's circumstances – See Section 9.4 Patient Welfare and Section 9.5

Patient Protection for details.

It is the responsibility of the hospital to ensure that their administrative process is fulfilled. Ambulance staff will leave a copy of the PRF with the hospital in the pre-arranged location, but should not be involved in the generation of the hospital patient record. LAS Staff should not carry out a verbal handover to reception staff, enter details on the hospital computer, or source the patient's hospital notes.

It is critical that the copy of the PRF is clearly legible. Staff should use a black ball point pen; press on a firm surface and sufficiently hard. If this copy is not legible, it should be over-written before being handed to the receiving unit.

Ambulance staff should inform EOC as early as possible of any potential delays as a result of the patient's condition. Any other delays should also be reported to EOC at the time of the delay (not retrospectively). A note will then be added to the electronic call log and this should also be documented on the PRF. Actions taken to mitigate and reduce such delays should also be recorded.

It is essential that ambulance staff ensure their availability is reported promptly to the EOC after patient hand over by the use of the 'Available on Radio' MDT status button. After reporting availability to EOC, the ambulance crew may return to station or undertake active area cover, as directed by EOC. Ambulance crews may avail themselves of local facilities providing they remain immediately available to respond to a call.

All non-disposable equipment and blankets taken with the patient should be retrieved, where possible, before leaving. This may be achieved by a direct swap. In the event of any essential equipment being left this must be documented on the PRF and EOC staff informed. All equipment must be identifiable to the LAS. Any equipment not retrieved by the end of the shift must be verbally reported to the oncoming crew. Every attempt must be made to retrieve the equipment during the course of the shift.

16. Conveyance to a Pre-Designated Ward or Department (not Emergency Department (ED) or other Emergency Referral Unit)

The London Ambulance Service NHS Trust conveys both acute and non-acute patients during the course of its work. The vast majority of these are conveyed to Emergency Departments or other Emergency Referral Units. However there are some cases, where requests are made to transfer patients to a pre-designated ward or department. In these instances the needs of the patient must remain paramount until responsibility for care has been properly and safely transferred; there is a need to be mindful of the impact on service delivery caused by excessive delays.

If ambulance staff have concerns over the clinical condition of the patient at the pickup point or en-route, they should consider the need to pre-warn the designated unit, via EOC, of their arrival. Where appropriate, ambulance staff may request via EOC that a clinician is available to meet the crew on arrival.

There are situations when the patient's condition deteriorates en-route, to the extent that in the ambulance staff's judgement it is deemed inappropriate to complete the designated journey. Should the decision be taken to divert to the nearest ED, EOC should be contacted immediately to:

- Pre-warn the ED via EOC (CASMEET).
- Notify the unit previously expecting the patient.
- Notify the referring clinician of the change.

Clinical escorts should be involved in this decision making process as appropriate.

For patient transfers to non-acute hospital destinations (i.e. mental health unit), it is advisable for EOC to obtain the following information:

- The location of the unit.
- The reception point for the patient.
- If out of hours, the entrance to the receiving facility and the method employed to gain access.

Where the patient is being conveyed out of hours and the entrance to the hospital/ designated receiving unit may be locked, ambulance staff should inform EOC of their pending arrival. EOC staff should contact the person on call in the hospital to allow for a member of staff to be ready to facilitate access.

However before leaving any patient, ambulance staff must ensure that the medical/ nursing staff at the designated receiving unit are informed of the patient's presence and provided with a clinical hand over.

17. Patients Not Conveyed to a Treatment Centre / Discharged from LAS Care

It is essential that ambulance crews make every reasonable effort to undertake a full patient assessment, treat and where indicated convey or direct patients to the most appropriate facility.

When an ambulance has been instructed by another health care professional, LAS staff must convey that patient to the agreed treatment centre. The only exception to this should if the patient is capacitant and adamantly refuses to travel to that destination. In this situation the crew concerned must make every effort to speak with the health care professional who made the arrangements and discuss the case. If required further assistance may be sought via the Clinical Hub.

Ambulance staff should not always assume that conveyance is required. Ambulance clinicians of the appropriate grade may, following diligent and comprehensive clinical assessment determine that conveyance by Emergency Ambulance is not necessary. The scope of practice of the Ambulance Clinician must be adhered to and the limitations of assessment in the out-of-hospital environment, therefore, in most circumstances the Ambulance Clinician should assume that whilst the patient may not require an Emergency Ambulance, they will normally require subsequent assessment by a clinician able to diagnose and treat their complaint. This may be at

an ED, MIU, UCC,WIC, pharmacy, or in primary care. In some cases referral through an appropriate care pathway, for example a Falls Team or District Nursing Service, may avoid the need for emergency admission.

Should a patient decline the treatment plan advised, or conveyance to hospital following assessment, staff should base their attempts to persuade the patient to travel upon clinical need/ urgency. It is essential, therefore, that all patients receive a comprehensive clinical assessment, and every appropriate effort made to persuade the patient to travel. It may be appropriate in these circumstances to take the patient to an alternative health care provider.

For a patient to make a valid refusal of treatment, they must retain the mental capacity to do so, refuse treatment voluntarily and have received sufficient information for that decision to be informed. Guidance on mental capacity and consent is detailed in OP/031 (Policy for Consent to Examination and Treatment) and LA5 (Capacity Tool).

Where the patient continues to decline conveyance despite appropriate advice, EOC must be informed and all relevant information recorded on the PRF. The patient (or parent / Guardian of the patient if under 18) should sign the reverse on the PRF to indicate treatment and / or transport has been refused. Where a patient lacks the capacity to make an informed decision crews may act under common law and the Mental Capacity Act (2005) in the best interests of the patient to affect conveyance in accordance with the Policy for Consent to Examination or Treatment (OP/031). Consider using the LAS form LA66 to assess best interests in a patient lacking capacity. Treatment and or transfer of patients in such circumstances must be achieved using the least restrictive means possible.

In situations where a patient declines or does not require conveyance to an Emergency Department (or other facility) and this decision is valid (i.e. the patient has capacity, the decision is informed and given voluntarily), LAS staff may leave the patient at scene. It certain situations, it may be appropriate to convey the patient to their home address or other location.

A completed copy of the PRF (and any ECG or other LAS documentation) must be left with the patient or a responsible person. Clear advice must be provided to the patient/ responsible person about any follow-up assessment or treatment that is required and where to seek further medical advice/ assistance if required (this may include advising to re-call 999).

If a referral to another Healthcare Professional or pathway has been made, full details of that referral must be recorded on the PRF.

17.1 Paediatric Patients Not Conveyed to a Treatment Centre

Children under two years old

All children under the age of 2 years should be conveyed to a hospital. This is to apply in all circumstances unless the parent(s)/ legal guardian(s) decline hospital. In certain situations, a child may have a Patient Specific Protocol (PSP) which should be followed and where the child fulfils the criteria on the PSP they need not

be conveyed to hospital.

If the parent(s)/ legal guardian(s) decline hospital, the child should be referred to their GP. If the crew have concerns for the patient, consideration should be given to a safeguarding referral and if necessary further support can be sought through the Clinical Hub. All these concerns should be documented in full on the PRF.

The parents/guardians are to be informed that if the patient deteriorates they can recall 999 or contact another healthcare professional service. A copy of the completed PRF must be left on scene.

Special care should be taken with children who have an apparent life-threatening event (such as apnoea and goes floppy) but appear fully recovered on LAS arrival at scene. These apparent life-threatening events can be linked to serious underlying pathology and can be warning signs which need to be followed up.

Children aged two to five

In the unlikely event an assessment has been undertaken and the clinician on scene deems that a child (aged two to five) does not need further assessment or treatment at hospital, the following should be undertaken:

Any observations taken must be appropriate for the patient. Expected normal ranges of observations are detailed in the current UK Ambulance Services Clinical Practice Guidelines . In addition to this, full details of the clinical assessment must be recorded on the PRF.

The parents/guardians must be informed that if the child deteriorates they can recall 999. A copy of the completed PRF must be left on scene. If the parents/guardians decline hospital, the same process as detailed for infants under 2 years of age must be followed.

In situations where a **child aged five to twelve** is not conveyed to hospital, serious consideration must be given to referring the patient to their GP for further assessment and treatment.

Staff should remain mindful that they can seek advice from EOC at any time, with further assistance provided by the Clinical Hub. The Clinical Hub is staffed by experienced paramedics who are able to support staff with patient related clinical problems, as well as any aspect of patient assessment or treatment.

18. Advance Decisions

An advance decision can be made by a patient to refuse specified treatment(s) in the event they are unable to consent for themselves or unable to communicate specific wishes regarding treatment they do not want to receive. An advance decision is binding if:

- The person making the decision was 18 or over at the time it was made and

had the necessary capacity.

- It specifies the specific treatment to be refused and the circumstances in which the refusal is to apply.

- The advance decision has not been withdrawn at a time when the patient still had the capacity to do so.

- A lasting power of attorney has not been appointed since the decision was made.

Advance Decisions for Life Sustaining Treatment

Where Advance Decisions relate to life-sustaining treatment the Mental Capacity Act 2005 dictates that in addition to the above:

- It **must** be in writing
- It must specifically acknowledge an intention to refuse treatment even if it puts the patient's life at risk
- It must be signed by the patient, or another in their presence if they are unable to sign it themselves
- It must be witnessed

It has been established that the criteria set out in the Mental Capacity Act must be met in full for an Advance Decision to be valid in law. In an emergency or where there is doubt about the existence or validity of an advance decision, treatment can be provided that is immediately necessary to stabilise or to prevent deterioration until such a time that the existence of the advance decision can be determined. Consider using LAS form LA67 to assess the validity of Advanced Decisions.

Further detailed advice regarding advance decisions can be found in the End Of Life Care section within the "Clinical" tab of the front page of the Pulse. (http://thepulse/uploaded_files/Clinical/end_of_life_care_guidance_003_23_april.pdf)

19. Dying Declaration

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

- Their cause of death.

- The circumstances of their death.

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

This constitutes a dying declaration and the information may be used in Court if the patient's death is connected with an illegal act. If a patient knows they are dying and makes a statement, ambulance staff should write down where possible, what was said and the patient should sign the declaration. Any declaration must be given to the police along with a statement from the ambulance staff concerned.

20. Do Not Attempt CPR (DNA-CPR) Forms / Allow a Natural Death (AND) Forms

NOTE: In the text below "DNA-CPR" also refers to "AND".

The guidance contained in Section 20 can also be found in the End of Life Care Section under the "Clinical " tab on the front page of the Pulse. (http://thepulse/uploaded_files/Clinical/end_of_life_care_guidance__001.pdf)

There is no standard DNA-CPR form. Many Trusts will record the decision on a form specific for that purpose. However, a resuscitation decision can still be documented on a letter or as an entry in the patient notes.

Staff should be certain beyond reasonable doubt that a DNA-CPR exists, but this does not necessarily mean that staff must see the physical DNA-CPR.
Where a crew have been notified by EOC and/ or the Clinical Hub that a DNA-CPR exists it is not necessary for the crew have sight of the physical document.
If clinical staff are informed by a registered health care professional that a DNA-CPR exists, it is reasonable to record the professional's name and honour the decision.

Staff should seek evidence that a DNA-CPR exists when unsubstantiated statements regarding DNA-CPR are made by the patient's relatives or carers. Staff should attempt to make contact with the patient's health care team to seek confirmation. If it is not possible, staff should contact the Clinical Hub.

If staff are presented with a DNA-CPR it is reasonable to check that the DNA-CPR is for the correct patient, and should be signed by the clinician making the DNA-CPR.

Many DNA-CPR forms will not have a review date. This is acceptable and indicates that the patient's condition is not expected to improve.

DNA-CPR decisions for a child may often be in the form of a letter from the lead clinician setting down a detailed resuscitation care plan. The parents have usually been involved in this care. In some circumstances the plan may advise that a limited resuscitation takes place (e.g. bag and mask and chest compression only). Where at all possible a Patient Specific Protocol will be created.

Under the AACE UK Ambulance Services Clinical Practice Guidelines (2013) Recognition Of Life Extinct (ROLE) procedures, resuscitation should be

discontinued in patients in “the final stages of terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal DNAR decision has been made.” There should be clear evidence of terminal illness and this should be detailed on the PRF. Terminal illness does not just include advanced malignancy, but includes conditions such as end stage cardiac and respiratory illnesses. Examples of such evidence include:

- Terminal illness documented in the patient’s District Nursing notes.
- Terminal illness documented in patient-held palliative care.
- Document evidence of use of the Gold Standards Framework (GSF).
- A Preferred Priorities of Care document setting out the patient’s care choices when they reach the terminal phase of their condition.

Evidence of parenteral palliative care agents such as:

- opioid analgesia
- anxiolytics e.g. midazolam, haloperidol
- anti-secretion medications e.g. glycopyrronium, hyoscine butylbromide

Occasionally a patient who has a DNA-CPR may suffer from a cardiac arrest from a clearly reversible cause such as choking. In these very rare occasions resuscitation should be considered. A DNA-CPR form purely relates to CPR and the patient should still receive treatment for any other condition. Therefore, it would be reasonable to discuss the most appropriate treatment with the patient and their medical team/ GP prior to conveying to the Emergency Department. If further advice is needed the Clinical Hub can be contacted.

Although there is no legal requirement for patients to consent to a DNA-CPR, usually where a patient has capacity they will be involved in the decision. Some patients may indicate that they do not wish to discuss resuscitation and in these cases the patient may not be aware of the DNA-CPR.

The only circumstances when a relative (or other adult who is not the patient) must be consulted in clinical decisions is where a person has appointed a proxy with Lasting Power of Attorney (Health & Welfare) and subsequently lost their capacity to make their own decisions. The extent of their decision-making capabilities depends on the scope stipulated in the LPA. The LA68 provides a detailed checklist for ensuring that than an LPA is valid and should be used to support decision making.

A DNA-CPR is simply a method of documenting the resuscitation component of a care plan and is a clinically led decision.

An Advance Decision is set out in law under the Mental Capacity Act 2005, which allows an individual to make decisions regarding their care and treatment should they subsequently lose capacity. An Advance Decision can be about any component of a patient’s treatment, not necessarily just resuscitation. Where an Advance Decision is for life-sustaining treatment the law requires that it is made in

writing, signed and dated, and witnessed.

The LA67 provides a detailed checklist for ensuring that than an Advance Decision is valid and should be used to support decision making.

21. Actions following Recognition of Life Extinct for an EXPECTED death

Recognition of life extinct is an important component of the London Ambulance Services work and one where due to the nature of the work our actions will be remembered by relatives and friends of the deceased and in some cases scrutinised by legal authorities. Once LAS staff have recognised life extinct, a patient's body will not be removed from scene by the LAS unless in the rare situation where the LAS has been directly requested to by HM Coroner. The flowchart overleaf shows the main actions that staff will need to complete before they can leave the scene, with completion of a PRF and an LA3 being paramount amongst them.

Deceased patient's fall into two groups; the "expected" death, or the "unexpected" death. Whilst this guidance cannot detail every circumstance which will decide whether a deceased patient belongs in one or other of these groups, there are the obvious examples of murder and traumatic death on the "unexpected" side, and terminal illness and palliative care patients on the "expected" side. A 45 year old male who suffers a heart attack and dies at home is much more likely to be an unexpected death and HM Coroner will need to be informed. A frail elderly patient in a care home with multiple co-morbidities including end stage organ disease is much more likely to be an expected death.

However, of paramount importance, no matter which group the deceased patient falls into, is the preservation of the dignity of the deceased, as well as the welfare of the relatives and carers. In the main the Police should only become involved if the death is unexpected, or in the case of expected death, there is no one on scene able to arrange undertakers, informing the GP etc...
THINK – how would you like your relatives to be treated by ambulance staff if they were in this position?

Specific Guidance

In the case of an "Expected Death" the GP of the patient will normally issue the Medical Certificate of Cause of Death (MCCD) and inform HM Coroner if required. The role of the LAS is to recognise life extinct, to preserve the dignity of the patient, ensure that the relatives / carers if present receive assistance if required, and to complete the necessary paperwork, (LA3 and PRF).

In the case of an expected death, it is acceptable to remove any LMAs / ETTs and cover IO / IV needles, used if resuscitation was performed. It is also absolutely acceptable to place the patient back onto a bed, (or another appropriate place),

rather than just leaving them on the floor where the resuscitation attempt was made, or where the patient was found. Considerthe dignity of the patient and the feelings of the family.

Where there is any suggestion the death is unexpected all medical devices must be left in situ and the body left in the position that it was at the point recognition of life extinct was performed. The position of the body should be noted on the PRF along with if the deceased was moved to facilitate examination or treatment
If the body is within the public view it should be covered this should ideally be with a foil blanket (straight out the packet) placed directly over the body and if needed this can be keep in place with a red blanket over the top

A flowchart of these actions is at Appendix 2.

22. “Unexpected” death

Under no circumstances should a deceased patient be removed from the scene without authority from the Coroner. The body must not be moved before the arrival of the police.

In cases of unexpected death, once recognition of life extinct has been undertaken, all invasive devices (endotracheal tube, intravenous cannulae etc.) must be left in situ. Any monitoring/ defibrillator electrodes must also be left in place.

When an unexpected death occurs whether in a private premise or a public place, the attending ambulance crew must complete form LA3. The crew must contact EOC to request the attendance of the police. The police must be informed of all unexpected deaths as it is their responsibility to establish if the death is suspicious and to liaise with the Coroner’s office. The Coroner must be informed of all deaths in their jurisdiction, however not all deaths will result in an inquest.

A copy of the completed PRF and LA3 must be handed to the attending police officer and the advice leaflet should be offered to the bereaved if they are present. LAS staff are then free to leave scene.

In situations where there is a responsible adult on scene and the crew feel in their professional judgement they are in a position to leave that person with the deceased, the person’s name must be documented on the PRF and the LA3. A copy of each must be handed to the person and they must be instructed to hand the documentation to the attending police officer. The crew must be absolutely confident that this process will be followed before leaving scene. On leaving scene EOC must be informed of the crew’s actions and the name of the responsible person left at the scene.

A flowchart of these actions is at Appendix 2.

23. Sudden Unexpected Death of an Infant (Under 2 years of age)

In the event of being called to attend an infant the following applies:

- Resuscitation should always be initiated unless clearly inappropriate.

- In cases where active resuscitation is not taking place and life has been recognised extinct, the infant must still be conveyed to an Emergency Department that accepts paediatrics. The hospital must be pre alerted, however it must me **clearly stated in the pre alert that the child is deceased and no resuscitation is being undertaken**. This will facilitate early examination by a Paediatrician.

- Infants must **not** be conveyed directly to the mortuary.

- Only in cases of severe trauma or decomposition should the infant be left on scene. Under these circumstances the crew must remain on scene and the police must be asked to attend.

- If significant concerns are raised at any stage about the possibility of abuse or neglect, a decision may be taken for the police to become the 'lead agency'. The police should be informed immediately that significant suspicion arises to ensure any further interviews with the family accord with the requirements of the Police and Criminal Evidence Act 1984. The LAS policy for children and vulnerable adults may also be of use in these circumstances.

- Keep the parents informed of your actions.

- A Child at Risk/ In-Need Report Form (LA279) must be completed for the deceased infant.

- A LA279 must be completed for all children at the scene at the time of the death; this is to ensure the welfare of those children. One form must be completed for each child at the scene whether they are related to the deceased infant or not.

- In cases where the infant is conveyed to hospital the name of the hospital clinician who receives the hand over must be clearly documented. In the rare situation where the infant remains on scene the shoulder number of the police officer in attendance must be recorded in the appropriate place on the PRF.

- A LA3 Recognition of Life Extinct (ROLE) form must be completed and handed to the hospital clinician or police officer.

24. Sudden Unexpected Death of a Patient Aged 2-18

In the event of attending the unexpected death of a patient aged 2-18 years old, the following applies:

- Standard ROLE procedure should occur as per current UK Ambulance Services Clinical Practice Guidelines. The patient should not be moved from scene without permission of HM Coroner.

- Keep the parents informed of your actions.

- A LA3 ROLE form must be completed and handed to the relevant police officer on scene.

- A Child at Risk/ In-Need Report Form (LA279) must be completed for the deceased patient.

- LA279 must be completed for all children at the scene at the time of the death to ensure the welfare of those children. One form must be completed for each child at the scene whether they are related to the deceased child or not.

- If significant concerns are raised at any stage about the possibility of abuse or neglect, a decision may be taken for the police to become the 'lead agency'. The police should be informed immediately that significant suspicion arises to ensure any further interviews with the family accord with the requirements of the Police and Criminal Evidence Act 1984. The LAS policy for children and vulnerable adults may also be of use in these circumstances.

A suitable manager from Team Leader rank or above should be sent to all deaths of a patient under 18 years old to ensure staff welfare and to support the above actions.

Sections 19.4 and 19.5 do not apply in cases of expected death of an infant, child or adolescent due to terminal illness. In most cases the Clinical Hub will be contacted in advance of a child entering the terminal phase of life, due to a life limiting illness, in order for patient specific plans to be put in place. The Clinical Hub can be contacted to assist staff with the clinical management of this patient group.

Further guidance can be found in the Medical Directorate bulletin – Sudden unexpected death in infants, children and adolescents dated 18th February 2009.
http://thepulse/uploaded_files/bulletins_other/medical_18feb09.pdf

<table>
<tr><th colspan="2">IMPLEMENTATION PLAN</th></tr>
<tr><td>Intended Audience</td><td>All LAS Staff</td></tr>
<tr><td>Dissemination</td><td>Available to all staff on the Pulse and to the public on the LAS website.</td></tr>
<tr><td>Communications</td><td>Revised Policy and Procedure to be announced in the RIB and a link provided to the document.</td></tr>
<tr><td>Training</td><td>The principles and practices contained within, or referred to via this policy are covered in the initial education and training of staff. Continuous professional development (CPD) education and training will be provided either by:
- Formal CPD courses at a Training Centre
- Complex Trainer/ Team Leader led events
- Bulletins/ Clinical Update
The precise method will be dependent upon the topic/ area being introduced/ revised, and will be advised by either the Education and Development Department and/ or the Medical Directorate.</td></tr>
<tr><td colspan="2">Monitoring:</td></tr>
</table>

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**
Duties, including Process for assessment, diagnosis and treatment (Paragraphs 4 and 8) How a referral is made to an appropriate centre of care, which may not necessarily be the nearest unit (Paragraph 10) Information that is given to the	Quarterly Sector Management Reports (includes CPI's - PRF compliance audit by the Management Information Team/Clinical Audit Team)	Assistant Director of Operations for each area reports to the Clinical Safety and Standards Committee	Clinical Safety and Standards Committee (and Trust Board if required)	Learning disseminated via various mechanisms including Medical Directorate Bulletins, Sector Management Meetings, Routine Information Bulletins, etc

patient, whether or not conveyance is required (Paragraph 6)				
How deviation from the national guidelines is managed (Paragraph 7)		The team leader will be responsible for initially dealing with any noted deviation from the current UK Ambulance Services Clinical Practice Guidelines		
Recognition of life extinct guidelines (ROLE) and Do not attempt resuscitation orders (DNAR) (Paragraph 18)				

Appendix 1

Definition of Responsible or Competent Person

(extract from TP/003 Statement of Duties to Patients)

- A competent or responsible 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.

London Ambulance Service **NHS**
NHS Trust

Actions following Recognition of Life Extinct

Recognition of Life Extinct by LAS Clinician

Unexpected Death

Is patient over two years old?

No Follow SUDICA Policy

Yes Contact EOC & request Police

DO NOT remove body

All invasive devices (ETT/igel/IV access device) to remain in situ

If the body is in a public place, then urgent liaison with the Police must be made to arrange, with the assistance of HM Coroner's Officer, removal of the body to a public mortuary. LAS to be used as an absolute last resort and where HM coroner has given permission.

If there is no responsible person on scene to organise an Undertaker, request Police via EOC

Police will contact Coroner to organise removal of body

Expected Death

In Hours

Notify patient's GP

Advise Palliative Care Team/Hospice of death (if applicable)

Remove / cover any invasive devices (ETT/igel/IV access device). Preserve dignity of deceased (place in bed / suitable location – be guided by relatives)

Complete LA3 & PRF

Advise family/care facility to contact Funeral Director for body to be removed

Out of Hours

Remove / cover any invasive devices (ETT/igel/IV access device). Preserve dignity of deceased (place in bed / suitable location – be guided by relatives)

Complete LA3 & PRF

Advise family/care facility to contact Funeral Director for body to be removed

Leave copies of paperwork on scene

Instruct family/care staff to contact patient's GP the next working day to obtain Death Certificate

NOTES:

OOH GPs will NOT routinely be expected to attend scene if LAS have completed ROLE.

OOH GPs will NOT be able to issue a Death Certificate.

Remember to complete LA279 for all deaths under 18

Document ALL actions on PRF

Contact EOC and advise of outcome