NON-TRANSPORT AND REFERRAL POLICY

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1 Statement

West Midlands Ambulance Service University NHS Foundation Trust (the Trust) is committed to the active management of risk. This Document has been developed to ensure all patients are provided with safe appropriate health care following full assessment by a Trust clinician.

The Trust believes that it is beneficial to patients, health and social care services, emergency departments and the Trust to provide local policies for staff to follow when making a transport decision and/or referring selected patients to these services. **The Trust will fully support staff who use the policy and procedure**

2 Introduction and Scope

2.1 The Trust objectives are to provide high quality, clinically effective patient care using Trust resources efficiently and expediently.

This document should be read in conjunction with the policies/procedures listed at the end of this policy.

The non-transport and referral policy and procedure is to enable and support ambulance staff to decide when a patient does not need to be transported to hospital in specific defined clinical scenarios. It also guides staff when to consider referral to alternative health care professionals that are most appropriate for the patient. This is to reduce the risk of adverse patient events and inappropriate decisions being made.

2.2 The key objectives of the policies covered in this document are:

- To ensure all patients receive high quality care by a suitably qualified clinician and discharged at scene
- To ensure that no patients are abandoned or left without care or access to care
- To ensure compliance to the Care Quality Commission (CQC) and the NHS Constitution
- To ensure WMASUFT achieves its strategic goals

3 Definitions

The definitions of groups of people for the purpose of this policy are as follows:

- **Clinician** – A health care professional (HCP) involved in the assessment or care of a patient to include the following:
- **Doctor** – A medical practitioner registered with the General Medical Council (GMC).
- **Critical Care Practitioner (CCP)** – A HCP (a Paramedic in this instance) who has undergone further specialist training in pre-hospital care, anaesthesia and rapid sequence induction (RSI). This is a non-exhaustive list.
- **Emergency Care Practitioner (ECP)** - A HCP (a Paramedic or Nurse) who has undergone further specialist training in primary care to include urinary catheterisation, medical model patient assessment, use of Patient Group Directives (PGD's), minor illness and minor injury diagnosis, wound management care and referral to Alternative Care Pathways (ACP's). This is a non-exhaustive list.
- **First Contact Practitioner (FCP)** - A HCP (a Paramedic in this instance) who has undergone further specialist training in patient assessment and the use of the medical model for recording patient history and clerking.
- **Advanced Paramedic** – A Paramedic who has undertaken the same training as an FCP but with the addition of minor wound closure to include gluing and steristripping.
- **Paramedic**– A HCP registered with the Healthcare Professions Council (HCPC) and practicing within the scope of the UK Clinical Practice Guidelines and the National Institute for Health and Clinical Excellence guidelines (NICE).
- **Student Paramedic** – An employee who is undertaking the Ambulance Associate Practioners programme or equivalent regulated qualification.
- **Nurse** – A HCP registered with the Nursing and Midwifery Council (NMC).
- **IHCD Technicians** – Ambulance personnel who have completed an Institute of Health and Care Development (IHCD) course.
- **Emergency Care Assistants** – (ECA's) Ambulance personnel who have completed an Institute of Health and Care Development (IHCD) course.
- **Computer Aided Dispatch System (CAD)** – Command and Control software utilised within the Emergency Operations Centre.
- **Emergency Operations Centre (EOC)** – Site where 999 calls are received and processed.
- **Clinical Support Desk (CSD)** – A team working within the EOC providing secondary triage to certain category C calls and advice to EOC and road staff.

4 Accountabilities and Responsibilities

4.1 The **Trust Board** are responsible for the effectiveness of this policy and procedures and for ensuring sufficient resources are available to support the implementation.

4.2 The **Quality Governance Committee** is responsible for the approval and monitoring of the policy.

4.3 The **Medical Director** is the nominated Executive Director with lead responsibility for managing the strategic development and implementation of clinical risk management, including clinical governance and effectiveness.

4.4 The **Director of Workforce and Organisational Development** is responsible for ensuring that the Education & Training staff are appropriately educated to provide training.

4.5 The **Strategic Operations Director** is responsible for ensuring that there is sufficient risk management in place for the management of patients. They must also ensure that responsibilities are effectively devolved throughout the organisation and that effective and timely briefing, training and guidance is given to support this.

4.6 The **Head of Emergency Operations Centres** (EOC's) will have a responsibility for:

- Ensuring EOC staff understands the contents of this policy and the associated documents.
- Ensure all appropriate staff received the necessary training.

4.7 All Trust staff involved in the care and non-transportation of patients have a responsibility to:

- Make themselves aware of the contents of this policy and associated procedures.
- Must follow the policy as laid out by the Trust.
- Attend mandatory training.
- It is the responsibility of all staff to identify risks and highlight these to an appropriate manager, usually through the Incident Reporting Policy procedure.

5 Risk Assessment of the Policy

5.1 Formal written risk assessment of the Policy will be assessed using the Trust Risk Matrix as per the Risk Management Strategy, and Risk Assessment Policy and procedures available from the Trust Website .This will be undertaken by the Professional Standards Group. Add in risk assessment reference.

5.2 Strategic and organisational risk assessments are placed on the Trust's Risk Register. The Risk Register is reviewed by the Health, Safety Risk & Environment Group; high risks are monitored by Executive Management Board. Adverse incidents will be monitored by the Learning Review Group.

6 Competence (Education and Training)

6.1 All staff involved in the care of patients within the WMAS University NHS Foundation Trust (WMASUFT) must ensure that they adhere to the standards as set out by approved Trust policies and guidelines, the scope of practice of their professional body and within the scope of the WMASUFT local policies.

All clinicians employed by the Trust must ensure that they are appraised with the most up to date current clinical practice.

Trust staff are reminded that registered health care professionals have a responsibility to maintain their knowledge and skills in accordance with their registered body's Policy:

- Doctors - General Medical Council
- Paramedics - Healthcare Professions Council
- Nurses - Nursing & Midwifery Council

Clinicians who feel that their knowledge and skills fall below the competencies expected should in the first instance contact their line manager.

6.2 The Education and Professional Development Department will facilitate education and training for clinical staff.

6.3 The Trust, as part of its ongoing process, will develop a Training Needs Analysis (TNA) which identifies statutory and mandatory training. This training may be in a variety of formats (e.g. in-house, external, work-based, briefing, e-learning etc).

The Trust's TNA for Statutory and Mandatory Training is the source document for stating what the Trust regards as Statutory and Mandatory Training, the groups of staff affected, and the frequency of the training. This TNA is reviewed and updated annually. Each year the Trust agrees and publishes an annual training plan against this TNA.

8 Non Transportation of Patients

8.1 The non-transportation of the patient must be based upon their clinical needs. Attending staff must make a full assessment of the patient appropriate to their presenting complaint before determining where the patient will be taken (reference appendix 1).

8.2 As a matter of law no-one can demand treatment which the clinician does not feel is clinically necessary or outside their scope of practice. .

9 Considerations in Non Transportation & Referral

9.1 To ensure patients are discharged from care safely and to protect the patient, the health care provider and the Trust, it is imperative that all patient contact results in a structured documented clinical assessment relevant to the patient's presenting complaint.

9.2 Accepting or refusing treatment is an adults right providing they have mental capacity see the Consent Policy and 'Mental Capacity and Consent' pocket guide for further guidance.

9.3 It must be recognised that the decision to accept or refuse treatment will frequently be influenced by the actions and advice given by the attending health care provider, who is often seen as the 'expert' by the patient.

9.4 The following guidance has been developed to assist healthcare professionals, together with patients, to make decisions about the management of the patient's health. It is intended to support the decision making process and is not a substitute for sound clinical judgment. Guidelines cannot always contain all the information necessary for determining appropriate care and cannot address all individual situations; therefore individuals using these guidelines must ensure they have the appropriate knowledge, experience and skills to enable appropriate interpretation.

9.5 Where a clinician requires support or advice in relation to clinical management of a patient to contact:

- Strategic Capacity Cell
- Clinical Support Desk
- Operational Manager

10 Health Care Referrals Which Subsequently Refuse To Travel

10.1 Where the patient has been assessed by a GP or other health professional and ambulance transport arranged (i.e. Doctors Urgent cases), then the patient must be conveyed as arranged. Any change to these arrangements must only occur after full consultation (where possible) with the health care professional requesting transport; this may be through direct contact or the EOC (In all cases, the EOC must be informed of such communications). The conversation should be thoroughly documented on the clinical record and the CAD notes, including times and the names of the parties in question.

11 Where a Decision Is Made Not To Convey The Patient

11.1 If a decision is made not to convey a patient, the points in the Non-Conveyance Check List (section 15) must be answered positively.

11.2 Patients should only be left after the attending crew has conducted an appropriate clinical assessment and all documentation has been completed. Ideally, a minimum of two sets of observations should be carried out before and after treatment has been provided. Observations must be completed with an appropriate time between them to allow for any change in the patient's condition to be identified. A final set of observations are to be conducted and documented just prior to discharge on scene.

11.3 Where patients are provided with self-care advice, this must be thoroughly documented and include specifics regarding the self-administration of medicines in line with the clinicians own competencies and scope of practice. This advice must be fully explained to the patient to ensure they have a clear understanding of the advice prior to them signing the Electronic Patient Record (EPR).

11.4 Where a decision is made not to convey a patient, the crew should inform the Emergency Operations Centre (EOC) of the situation. This information should then be recorded on the Computer Aided Dispatch System (CAD) in the EOC. The attending crew should then complete either a Electronic Patient Record (EPR)_ or a Patient Report Form (PRF) and ask the patient or guardian to sign the form.

12 Refusal to Consent to Examination, Treatment or Transfer

12.1 Where patients decline examination, treatment or transfer after full explanation of the risks of doing so and against the advice of the crew, and the patient has the capacity to make that decision, the crew should inform the EOC of the situation. This information should then be recorded on the CAD in the EOC. The attending crew should then complete a EPR/PRF and ask the patient or guardian to sign the form.

12.2 If the patient or guardian refuses to sign the EPR/PRF, then this should be recorded on the form and recorded on the CAD in the EOC. Attempts should be made to identify an independent witness and ask them to sign the EPR/PRF.

12.3 Patients should only be left after the attending crew has conducted an appropriate clinical assessment and all documentation has been completed. If an appropriate assessment cannot be completed, then a full explanation must be recorded on the EPR/PRF.

13 Patient 'Safety Netting'

13.1 All non-transported patients must be left with a copy of the PRF and/**or** a copy of the Trust`s Non-Conveyance Advice Leaflet if using the EPR system. The PRF must include detailed health care advice written in full not just 'advice given'. The Non-Conveyance Advice Leaflet must be completed as per current Trust guidance and the Electronic Patient Record must state that this advice leaflet has been both explained and duly left with the patient or a responsible adult on the patients behalf.

The patient or relative should be made aware that in the event of needing to seek further medical help, they should present the PRF/Non Conveyance Advice Leaflet to the health care professional.

13.2 Consideration should be given to informing the patient's GP if a decision is made to leave the patient at home. The decision should be made based on the presenting complaint, clinical findings and associated co morbidities.

13.3 Patient call backs or welfare calls should only be completed by EOC staff on a recorded telephone system and will be fully documented on the CAD system.

14 Alternative Pathways

14.1 Alternative pathways should be utilised where available. Regional access is now available through the Strategic Capacity Cell (SCC), Clinical Support Desk (CSD) and the Directory of Services. This lists the current alternative care pathways and gives access to poisons advice through Toxbase.

14.2 Do not promise a GP visit to the patient – this is up to the doctor's clinical judgement.

14.3 Accurate comprehensive documentation, decision-making made in the patient's best interest, and clear communication and follow-up will protect patients, the health care provider and the Trust in the event of a misdiagnosis.

15 Non-Transportation Checklist

Consider transporting/referral to an appropriate health care facility if you are unable to answer yes to all of the following;

- Does the patient have the Mental Capacity to consent or refuse to treatment? If they haven't are you acting in their best interest and are relevant safeguarding's in place? All Examination findings are within normal limits and where possible checked against objective assessment tools e.g. NEWS2, GCS, Peak flow etc?

- If the patient receives treatment - observations are repeated post treatment and compared?
- Options discussed and agreed with patient?
- Advice is recorded in full, including any risks from not being conveyed and explained to patient?
- Copy of PRF/ Non-Conveyance Advice Leaflet given to patient?
- 'Safety Netting' in place?
- Advice from the SCC and CSD where appropriate?

16 Patient Groups

16.1 Patients are categorised by age into the following definitions by The United Kingdom Resuscitation Council (UKRC)

- Adults are defined as patients sixteen years and over.
- Children are defined as patients from 1 year to 16 years of age.
- Infants are defined as patients aged 1 day to 1 year.
- New born babies are defined as patients during the transition from birth to successfully breathing once separated from the placenta.

16.2 Patients are also categorised by their presenting medical condition into:

- Trauma patients are defined as those with injury or shock to the body from violence or accident.
- Medical patients are defined as those with a disease or illness.
- Mental health patients are defined as those with psychological or behavioural pattern associated with distress or disability that occurs in an individual that is not part of their normal development or culture.
- Patients with a disability - Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives. (World Health Organisation 2010 (WHO)).

17 High Risk Patient Groups

17.1 Patients suffering from any disease that affects cognitive function e.g. dementia, mental health illness, substance dependence including patients with a long-term disease which may affect a person's capacity to consent or a patient who is at risk of social isolation should be considered a 'high risk' patient group.

17.2 All callers/patients should be deemed to have the capacity to consent unless assessed otherwise. Some of these patients may lack capacity to consent under the WMAS Consent Policy and a referral to the safeguarding team as per the Safeguarding Children and Adults at Risk Policy/Procedure may be appropriate. Guidance may be sought from the clinician within the EOC.

18 Children

18.1 Children under 1 year.

Infants and small children can be difficult to assess, and ambulance clinicians currently receive limited training in the assessment and management of paediatrics with this being predominantly confined to the management of emergency situations. There are also complex social considerations which may not be immediately apparent to the attending clinician.

The Royal College of Emergency Medicine recommends that any child under 1 who attends the emergency department should be seen by a senior doctor before they are discharged. It is also good practice that a child with a fever has the source of the fever identified and the fever decreased before discharge from ED. A thorough clinical examination including examination of the ears and throat is also mandated.

Therefore, all children under 1 year must either be:

- Conveyed to an emergency department,
- Their ongoing care arranged directly by the attending clinician with another registered Health Care Professional,
- Their ongoing care arranged remotely by a clinician in the clinical hub directly with another registered Health Care Professional.

They must not be discharged at scene without a direct referral to another registered Health Care Professional. This must be fully documented on the EPR/PRF including the name of the registered Health Care Professional the patient is referred to. If the parents or guardian state, they will take the patient to a GP or Walk in Centre later then the WMAS clinician must still ensure a direct referral is made in order to fully safety net the child and ensure ongoing care.

If parents or guardians refuse admission to hospital that is clinically in the patient's best interest, then support should be sought from the duty Operational Manager and or Clinical Support Desk. Dependant on the circumstances consideration must be given to making a safeguarding referral if there are any concerns of neglect or other abuse. See the Trusts Safeguarding Children Young People and Adults at Risk Policy for further guidance.

18.2 If a child has been seen by a health care professional with the same or similar presenting symptoms within the previous 48 hours and their condition has not improved or has deteriorated, then the child should be conveyed to an appropriate health care facility for further paediatric assessment.

18.3 The routine transportation of a child to a health care facility is not always necessary; in such cases other means of transport for further assessment may be considered. Discharge of such patients should be based on a sound clinical assessment. If in doubt conveyance to an appropriate healthcare facility should be undertaken.

18.4 The most important skill in managing paediatric emergencies is patient assessment. Good assessment allows the child with actual or potential life-threatening illness or injury to be rapidly identified and managed. Recognition of the seriously ill or injured child involves the identification of a number of key signs affecting the child's airway, breathing, circulatory or neurological systems.

A full assessment must be carried out and documented to include a respiratory rate, heart rate, SP02 and GCS/AVPU in all cases. A temperature to be taken in a child who presents with a medical illness, if the child is less than 1 month of age they will need to be referred to an appropriate care pathway for assessment.

A blood glucose reading should be taken in all significant medical and trauma cases, it should not form part of the routine examination of a paediatric patient unless indicated.A peak flow measurement for should be undertaken for all respiratory complaints. A pain score in both medical and trauma related cases or if a child is experiencing any level of pain both pre and post treatment.

If any of the above are unable to be carried out the reason/rationale must be documented.

19 Documentation

19.1 Appropriate notes **MUST** be added to the EPR/PRF/ as per the Trusts Patient Clinical Records Policy and Procedures

20 Equality and Diversity Statement

20.1 This policy embraces Diversity, Dignity and Inclusion in line with emerging Human Rights guidance. We recognise, acknowledge and value difference across all people and their backgrounds. We will treat everyone with courtesy and consideration and ensure that no-one is belittled, excluded or disadvantaged in anyway shape or form.

20.2 A full Equality Impact Assessment (EIA) screening tool has been completed in relation to this policy.

20.3 The EIA highlighted no negative impacts for any patient groups covered by this policy.

21 Implementation Plan

21.1 The Strategic Operations Director will be responsible for implementing and distributing this Policy.

21.2 The Policy will be made available to all operational staff in the Trust via the Trust intranet site.

22 Policy Review

22.1 A review of the policies effectiveness will be undertaken by the Medical Director 3 months after implementation. This will ensure the policy is robust.

22.2 This policy will be reviewed in 2 years from the date of approval.

23 References

- UK Ambulance Service Clinical Practice Guidelines 2017
- WMAS Risk Management Strategy
- WMAS Health and Safety Policy
- WMAS Incident Reporting Policy
- WMAS Process for Monitoring Clinical Records
- World Health Organisation 2010
- WMAS Consent Policy.
- WMAS Safeguarding Children and Vulnerable Adults Policy and Procedure
- The Caldicott Committee Report on the Review of Patient Identifiable Information.
- The Data Protection Act 2018.
- WMAS Patient Clinical Record Policy and Procedure.
- Safer Manual Handling Policy.

Appendix One