Northern Ireland Ambulance Service
Health and Social Care Trust

Appropriate referral / transport guideline

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Contents

1.0 Introduction

1.1 This guideline is aimed at supporting the vision of “Transforming Your Care” by ensuring patients receive the right care in the right place at the right time.

1.2 The demand for emergency ambulances is increasing every year and the range of conditions and clinical presentations of patients continue to challenge both the emergency medical dispatcher (EMD) and the attending paramedics / EMTs. Sir Bruce Keogh (2013) has recognised that our “current services are unsustainable”. Traditionally the only option for attending paramedics was to transport patients to the Emergency Department (ED). However, the Keogh Report (2013) identified from their analysis that 50% of 999 calls did not need ED attendance. The ED should now be regarded as just one of a range of pathways that can be utilised to ensure the patient receives the most appropriate care. Success in combating the increasing workload will rely upon our ability to accurately assess, treat and refer patients to the most appropriate care providers. Our ability to adapt to this new way of working will see patients receive more timely and appropriate care, with the overall patient experience being enhanced.

1.3 It is widely recognised that not every patient who contacts the ambulance service requires an ambulance response. A proportion of patients can be safely managed by telephone triage which is known as “hear and refer” – a service currently undertaken by Clinical Support Desk (CSD) Paramedics within NIAS Emergency Ambulance Control. When an ambulance does attend to a patient, It is also recognised that not every patient will require transport to the ED. Paramedics can now safely manage patients in the community by utilising “see and treat” and “see, treat and refer” appropriate care pathways. Examples of appropriate care pathways (ACPs) include referral to:

- The General Practitioner (GP)
- A minor injury unit
- A respiratory nurse
- A frail elderly assessment unit
- A district nursing team
- A diabetic nurse specialist

1.4 Accessing these referral pathways will ensure the patient receives the most appropriate care at the right place at the right time. Attending paramedics should be mindful that inappropriate transport to an ED may not be in the patient’s best interests. Inappropriate ED attendance may lead to a poor patient experience and also an increased risk of contracting a hospital acquired infection.

1.5 This guideline is designed to assist paramedics with their clinical decision making. By supporting paramedics to safely refer patients to the most appropriate care, patient experience is enhanced, paramedic confidence is increased and patient safety is maintained.

1.6 Employing this guideline will also result in a reduction in ambulance utilisation and will ensure ambulances are available for genuine life threatening emergencies. Demand on local ED’s will also be reduced.

1.7 The guideline also offers guidance to staff regarding patients who refuse treatment or transport despite there being a clinical need.

2.0 Principles of Consent and Mental Capacity

Patients have fundamental legal and ethical rights in determining what happens to their own bodies. Valid consent to treatment is therefore central to all forms of healthcare. Seeking consent is also a common courtesy between health care professionals and their patients.

2.1 The Department of Health and Social Services and Public Safety (2003) and the Department of Health (2001) offer the following guidance regarding consent.

- It is a general legal and ethical principle that valid consent must be obtained before commencing an examination or starting treatment. The principle reflects the right of the patient to determine what happens to their own bodies and is a fundamental part of good practice.

- The professional providing the treatment or care is responsible for ensuring that the patient has given valid consent before treatment or care begins.

- For consent to be valid, it must be given voluntarily by an appropriately informed person (the individual or where relevant someone with parental responsibility for a young person under the age of 18) who has the capacity to consent to the intervention in question. The patient should be informed of the proposed clinical intervention or assessment and advised of all the facts and potential risks associated with it. Consent generally remains valid unless it is withdrawn by the patient, however, new information must be given to the patient as it arises and consent regained.

- Coercion invalidates consent and care must be taken to ensure that the patient makes a decision freely. Coercion should be distinguished from providing the patient with the appropriate reassurance concerning their treatment or care, or pointing out the potential benefits of treatment or care for the patients' health and well-being.

- Capacity to consent is the ability to comprehend and retain information material to the decision, especially as to the consequences of having or not having the intervention involved. It is the ability to believe the information and to use and weight this information when making a decision whether to consent or withhold consent.

2.2 Seeking consent

Before you treat, examine or care for patients, you must obtain their consent. Valid consent can only be given by the patient. Patients can withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to caring for or treating them. Consent must be continuous, if previously unexplained

treatment is recommended to be carried out, further consent must be gained beforehand. Three basic tests are used to ensure consent is valid:

1) Does the patient have capacity? Are they able to comprehend and retain information material to the decision, believe it and use that information to make a decision while bearing the full consequences in mind?

2) Is the consent given voluntarily? Consent is only valid if given freely with no pressure or undue influence to accept or refuse treatment.

3) Has the patient received sufficient information? The patient must understand in broad terms, the nature and purpose of the procedure as well as the potential consequences of consenting to it or refusing to consent. The paramedic is responsible for ensuring that the patient has been provided with all the required information to make a decision. Failure of the paramedic to provide the required information may be regarded as a failure of that paramedic to carry out their duties.

Patients also need to be able to communicate their decisions. Care should be taken not to underestimate the ability of a patient to communicate, whatever their condition. Paramedics should take all steps that are reasonable in the circumstances to facilitate communication with the patient using interpreters or communications aids where appropriate, while allowing for the urgency of the situation.

Adults are presumed to have capacity but where doubt exists, the paramedic should assess the capacity of the patient to make the decision in question. The assessment and conclusions drawn from it should be documented on the PRF.

2.3 Refusal and withdrawal of consent

It is not uncommon in pre hospital healthcare situations for patients to refuse care or treatment. Although patients may refuse, there is still, in certain circumstances, an on-going moral duty and legal responsibility for paramedics to provide further intervention especially if there is a risk to life.

If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment, or decides to withdraw their consent at any time, the paramedic should stop the procedure, establish their concerns and explain the consequences of withdrawal. If however, withdrawing the procedure at that point may reasonably be seen to put the patient's life at risk, the paramedic may continue until such risk no longer applies.

Withholding or withdrawing treatment is not an option for paramedics unless consent is withdrawn.

2.4 Patients without capacity

There is currently no mental capacity legislation in Northern Ireland; however the introduction of new legislation is pending.

Adults, who usually have capacity, may, especially in emergency situations become temporally incapacitated. The current draft mental health Bill states that a person lacks capacity if they are “unable to make the particular decision because of an impairment of, or a disturbance in the functioning of the mind or brain”. In any decision around non-transport and / or patient refusal, the patient must be assessed as to whether they have capacity i.e. that they are able to make their own fully informed decision.

It is important to consider if a patient is unable to make a decision because their mental capacity is affected by illness or disability, or the effects of drugs or alcohol (temporary incapacity).

Where a patient is incapacitated, the paramedic can act within the Doctrine of Necessity and is permitted to apply treatments that are necessary and no more than is reasonably required pending the recovery of capacity. This includes any action taken to preserve the life, health or wellbeing of the patient, and can include wider social, psychological or welfare considerations.

The Doctrine of Necessity is common law that allows clinicians to act “in the patient’s best interests”. The Health and Care Professions Council (HCPC) (2012) state in their standards of conduct, performance and ethics that the professional should act in the best interests of the patient but must also not do anything that will put the health, safety and wellbeing of the patient in danger. If the attending paramedic is acting in the patients best interests, this should be documented in full on the PRF.

A person is unable to make a particular decision if they are unable to do one or more of the following:

- Understand information given to them.
- Retain that information long enough to be able to make the decision.
- Weigh up the information available to make the decision.
- Communicate their decision; this could be by using sign language or even simple muscle movements such as blinking an eye or squeezing a hand. (If this is their normal method of communication).

For patients who have a clinical need but lack capacity and refuse to attend an appropriate facility, the paramedic should attempt to contact the GP / out of hours GP. The paramedic should make every effort to directly contact the GP, however, it is recognised that there will be certain occasions when EAC assistance will be required. The Police Service of Northern Ireland (PSNI) assistance should also be considered. The paramedic should remain on scene until the GP arrives unless the patient can be safely left in care of a responsible person and all the relevant documentation has been completed. EAC should be kept informed of any potential delays.

3.0 History taking and assessment

3.1 A thorough history and comprehensive patient assessment are vital when referring on to another health care professional or deciding that a patient requires no onwards referral. Paramedics should refer to both their ambulance service training

and Association of Ambulance Chief Executives (AACE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) UK Ambulance Service Clinical Practice Guidelines 2016 and 2017. Both the patient history and assessment should be clearly documented on the PRF. A number of tools including the national early warning score are available on the back of the PRF to assist with clinical decision making.

3.2 Any clinical assessment must consider what the abnormal clinical signs are in relation to the patient's normal presentation.

3.3 A discussion should always take place with the patient and (with their consent) relatives/carers about the most appropriate care plan for the patient. The patient's choice should be respected if they are assessed as having capacity.

3.4 Following a clinical assessment, the patient may not travel to hospital for a number of reasons:

- The patient refuses.
- A&E Transport not required / Patient making own way.
- Patient referred to an appropriate care pathway.
- Patient referred to non-emergency ambulance for transport.
- No further clinical intervention required following assessment.

4.0 Documentation

4.1 Thorough documentation and evidence of clinical decision making are essential. As described in the section on consent, the patient (and their family / friend if appropriate) should be involved in the decision making process. Documentation **MUST** always be full and comprehensive and per NIAS PRF completion guidance and include:

- Details of all clinical assessment, examination and history taking.
- Documentation of any advice given to the patient / carer / relative / responsible person. This advice should be specific to the patients presenting complaint. The carbon copy of the PRF provides advice regarding a number appropriate care pathways and a range of clinical conditions. The free text box however must be used to provide specific advice relating to the patient's condition if not already provided on the carbon copy of the PRF.
- Documentation of any referral made and name of person / unit accepting the referral
- Documented expected response time of other attending professionals if appropriate e.g. PCS crew for transport or GP / Health Care Professional for home visit.
- Where a patient refuses treatment / transport, then there should be clear documentation as to why the patient refused and if they have capacity. The patient must be made fully aware of the consequences of their refusal and this should also be documented on the PRF.
- Document whether patient has been left in care of a responsible person.

- The content of the patient report form should be explained to the patient / family / friend.
- A copy of the PRF should be left with the patient.

5.0 Patient Handover and Documentation

5.1 All referrals must be documented on the PRF.

5.2 A copy of the PRF should be left with the receiving staff or patient.

6.0 General principles for patients who are not transported or are referred.

6.1 The concepts of consent and capacity should always be considered.

6.2 There will be occasions when this guideline will be used in conjunction with other clinical guidelines (both local and national). There are now a range of appropriate care pathway guidelines that can be used in association with this guideline. Information regarding these pathways can be accessed via the NIAS app.

6.3 Thorough clinical assessment and robust documentation is required for all patients including those who are either not transported or are referred. If a patient does not consent to any part of this assessment, this should also be documented on the PRF.

6.4 Where a patient is not transported or has been referred to an appropriate destination or for home assessment by another healthcare service, they (and their family / friend if appropriate) should be involved in the decision making process. The patient report form should be left with the patient and the paramedic should explain the content of the form to the patient ensuring that they understand it.

6.5 Where a patient is not transported or has been referred to an appropriate destination, they should ideally be left in the care of a responsible person. The paramedic should use the following characteristics to help decide if someone can be defined as a “responsible person”:

- Has access to a telephone
- Understands what has happened to the patient and what it is the paramedic is trying to achieve.
- Is able to supervise the patient until either the patient can self-manage or they have accessed other forms of healthcare.
- Knows the patients GP contact details (or contact details of the ACP if the patient has been referred e.g. the address if a MIU)
- Is able to communicate with the emergency services to recall the ambulance if required.

It is acknowledged that it is not always possible to leave a patient in the care of a responsible person. Where this is the case, the responding crew should make every attempt to make the patient as safe as possible, e.g. calling relatives and asking

them to visit or ensuring that the patient has access to their Careline necklace / bracelet where one is available.

6.6 If in any doubt about a patient's condition then the patient should be encouraged to travel to hospital.

6.7 If a patient insists on being transported to hospital even though there is no clinical need for an ambulance, their wish should be respected. Paramedics should feel confident to have a discussion with the patient regarding the appropriateness of using an emergency ambulance. Paramedics may suggest alternative forms of transport such as using their own car where this is appropriate.

7.0 Refusal to Travel / Refusal of Referral

7.1 It is not uncommon to find patients who refuse treatment or admission to hospital, despite a clear clinical need being identified by the attending paramedics. These patients should be regarded as high risk. If, despite reasonable persuasion, the patient refuses treatment, it is not acceptable to leave them in a potentially dangerous situation without any access to care or follow up.

7.2 Patients refusing treatment / transport should be assessed for mental capacity. Where a patient lacks the capacity to make an informed decision, the paramedic may act under the common law of "doctrine of necessity" to effect conveyance dependent upon the circumstances and condition of the patient. The PSNI can be requested via EAC if required.

7.3 EAC should be informed regarding any patients who have capacity and are adamantly refusing treatment / transport despite there being a clear clinical need. The patient should be left in the care of a responsible person. Documentation should address any significant red flag signs or symptoms and also offer further advice on what the patient should do should their condition deteriorate after the paramedic has left. A copy of the PRF should be left with the patient / responsible person. The form should be signed by the attending paramedic and patient / responsible person. In the case of double crewed vehicles, it is advisable that both members of staff sign the form. If there is no responsible person on scene, the paramedic should contact the next of kin / family friend and request their attendance. The responsible person should be instructed to re-call the ambulance service or seek other medical assistance if appropriate should the patient's condition deteriorate.

7.4 If the patient is in a public place, they should be left in the care of a responsible person. That person should be advised to take the patient home or to a place of safety.

7.5 The paramedic should make attempts at accessing other appropriate forms of care e.g. the patients GP. Documentation should address any significant red flag signs and symptoms and also offer further advice on what the patient should do should their condition deteriorate after the clinician has left. A copy of the PRF should be left with the patient / responsible person. The form should be signed by the paramedic and the patient / responsible person unless they refuse to sign it. In the case of double crewed vehicles, it is advisable that both members of staff sign

the form. The responsible person should be instructed to re-call the ambulance or seek other medical assistance if appropriate should the patient's condition deteriorate.

7.6 If there is no-one willing to take responsibility for the patient and the patient is incapable of leaving the scene unaided or concern is felt for the patient's welfare, the crew should consider police assistance.

7.7 Where a patient is reluctant to be conveyed to a hospital, the clinical needs of the patient must determine the degree to which staff attempts to persuade the patient to travel. It is therefore essential that a thorough patient assessment is completed. It may be appropriate to take the patient to an ACP e.g. Minor Injuries Unit.

7.8 The mechanism of injury or history of medical presentation must be clearly recorded, even where there is no apparent injury. If the patient has been involved in a significant incident where there is clear potential for an injury they should be advised to attend ED. This may not necessarily mean transport via ambulance. It may be appropriate for the patient to make their own way.

7.9 For any patient who refuses either treatment or transport, they should be made fully aware of the potential consequences of their refusal. This should be documented on the PRF.

7.10 Ambulances are a valuable but limited resource that should only be used for genuine emergencies. If operational crews feel that they have been called with the sole aim of transporting the patient home, then other options should be explored and consideration given for requesting the PSNI.

7.11 The paramedic should always keep EAC informed of any delays on scene.

8.0 Patients in transit who refuse further care

8.1 If the patient either recovers during transit or changes their mind and is adamant that they wish to leave the ambulance, the paramedic should make every attempt to persuade the patient to continue to the hospital and not leave the vehicle. The paramedic should explain the reasons why they need to continue the journey and if necessary assess the patient's mental capacity while doing this.

8.2 If the patient does not have any mental capacity issues or a life threatening condition and is capable of leaving the vehicle without assistance and is adamant that they wish to leave the ambulance, then the crew should park when and where safe to do so and allow the patient to find alternative transport home. The paramedic should complete the PRF documenting the occurrence. EAC should be informed.

8.3 If the patient demonstrates any of the following:

- Mental capacity issues / Life threatening condition
- Unable to leave the vehicle without assistance
- Attempting to leave a moving vehicle
- Insisting on leaving the vehicle where the area is unsafe or there are no other easily accessible transport networks

The crew should park the vehicle when and where safe to do so and inform EAC that PSNI assistance is required. If the patient leaves the vehicle, the crew should attempt to remain in contact with the patient providing it is safe to do so.

8.4 On rare occasions where a patient becomes violent or aggressive during transit, there may not be time to find a suitable parking place. If the crew feels their personal safety is in jeopardy, then the driver of the vehicle should carry out an emergency stop. PSNI assistance should then be requested. On arrival of the PSNI, there should be clear discussion regarding any ongoing need for medical attention and the most appropriate method of transport to a place of care. If it is established that there is no ongoing medical need, then the patient should be handed over to the PSNI. The rationale for this decision and the PSNI officers name must be recorded on the PRF.

9.0 A&E transport not required / patient making own way

9.1 Following assessment and treatment of a patient it may be apparent that attendance at hospital is not required and / or the patient is able to make their own way. Once the paramedic has established that no clinical intervention or further assessment / monitoring is required during transport, it is acceptable for paramedics to suggest alternative means of transport. Paramedics should not get involved in confrontation and if the patient has no other form of transport available, then the crew should transport by ambulance.

9.2 Where a patient is making their own way to ED or an appropriate care destination, they should ideally be left in the care of a responsible person. The patient report form should have clear documentation of patient assessment, diagnosis and referral pathway. Significant red flag signs / symptoms should have been addressed and advice given in relation to what the patient should do should their condition deteriorate. This should be documented on the PRF and a copy of the PRF should be given to the patient.

10.0 Rapid Response Vehicle (RRV) paramedic referral for non-emergency transport.

10.1 There are occasions when an attending RRV paramedic decides that a non-emergency vehicle is suitable to transport the patient to hospital. On these occasions, the paramedic should satisfy themselves that no clinical intervention or assessment / monitoring will be required during transport. The patient report form should have clear documentation of patient assessment, diagnosis and referral pathway. Significant signs / symptoms should have been addressed and documented on the PRF.

10.2 The paramedic should contact EAC on 02890 404040 and advise the EMD / Regional Pressures Coordination Centre (RPCC) call taker that they would like to book an ambulance via the Health Care Professional pathway. The EMD / RPCC call taker will ask a series of questions to ascertain the following information:

- Original call number
- Time frame for ambulance to arrive
- Does the patient need to travel alone?
- Destination hospital
- Name of patient
- Patient telephone number
- Any other important information

10.3 Once the call has been accepted, the paramedic can leave scene. The patient should be left in care of a responsible person and have received advice on what to do should their condition deteriorate. The patient / responsible person should also be given a copy of the patient report form. On occasions, the patient may be alone and it is not possible to leave them in the care of a responsible person. The paramedic should use clinical judgement to decide if it is safe for the patient to be left alone. This decision and the reasons for the decision should be documented on the PRF.

10.4 If the RRV paramedic decides that an accident and emergency ambulance is required to transport the patient, then the RRV paramedic must remain on scene until this vehicle arrives.

11.0 No further clinical intervention required

11.1 It is not uncommon for NIAS paramedics to identify patients where no further clinical interventions are required and transporting the patient to ED or referring the patient to an ACP would not necessarily be in the patients best interests. The paramedic should exercise caution, recognise their own ability and act within their scope of practice. After comprehensive history taking and a thorough patient assessment, the patient should be left in care of a responsible person and have received appropriate advice on what to do should their condition change. The patient / responsible person should also be given a copy of the patient report form.

11.2 On occasions, the paramedic may identify a patient whereby no onward referral is required but there is no responsible person available. The paramedic should use clinical judgement to decide if it is safe for the patient to be left alone. This decision and the reasons for the decision should be documented on the PRF.

12.0 Referral Pathway Guidelines

12.1 Not every call to the ambulance service will require an ambulance response. Experienced clinicians working on the Clinical Support Desk will be able to utilise the “hear and refer” strategy. Hear and refer involves the clinician identifying suitable calls and undertaking a comprehensive telephone consultation. On occasions this may still result in the clinician deciding that an ambulance is appropriate however, for

the majority of cases, the clinician will recommend that the patient makes their own way to an appropriate care pathway e.g. the local pharmacy or MIU.

12.2 There are a number of appropriate care pathways other than the ED that paramedics can access if appropriate. These include Minor Injury Units (MIUs), frail / elderly units, alcohol recovery centre; district nursing teams; community respiratory nurses; diabetic specialist nurses; palliative care teams and falls teams. As the Transforming Your Care programme evolves, further ACPs may be added. Where an ACP has been used, the responding clinicians should ensure that the correct MDT code has been used when clearing from the call.

12.3 Patients should be encouraged to make their own way to an ED or alternative destination where safe to do so. The paramedic must satisfy themselves that the patient is safe to use other forms of transport.

12.4 The paramedic must ensure that all patients are fully assessed before any decision is taken to transport or refer to an alternative destination. Paramedics should familiarise themselves with new ACPs by remaining current with Operational Updates.

12.5 EAC should be advised of all cases where a patient does not travel to hospital or travels to an alternative destination. The reason will be recorded on the call log and the call closed with the appropriate “Stop” code.

12.6 If, during handover, clinical staff at an ACP e.g. minor injury unit request NIAS staff to transport the patient to ED that request should be carried out and noted on the PRF and EAC informed.

12.7 Consideration should always be given to the local referral pathways available. Further information regarding referral pathways can be gained from EAC.

12.8 For all referrals the patient must consent to their information being passed on to another service and agree to the referral being made. This should be documented on the PRF.

13.0 High Risk Patients

13.1 Children

Because of their vulnerability, paramedics must exercise extreme caution if the patient is 16 years or under. Paramedics should have a lower threshold for transporting children. Considerations should be given for any safeguarding issues. Attempts should be made to contact the parent / guardian or their school if within school hours. If no one is willing to accept responsibility for the patient and they are incapable of leaving the scene unaided or there are welfare concerns then the PSNI should be requested.

Children under 2

All children under the age of 2 should be transported to hospital or referred to an appropriate health care professional / ACP. The attending paramedic may not have

access to important information about a child that could be accessed from hospital or primary care. If following assessment, there is no requirement for ongoing treatment / continuous assessment by the paramedic, it is appropriate to suggest that the parents or a responsible adult transports the patient to the ED.

Children aged 2-5

All children aged 2-5 should be referred to their GP even where they appear to have fully recovered and have no further need for medical assessment / treatment. The paramedic may not be aware of information that can be accessed in primary care.

Where a child or the parent / guardian refuses treatment / transport, a thorough patient history and clinical assessment should be documented. The patient or parent / guardian should be given appropriate advice and a copy of the PRF left with them. Patients who have refused transport / treatment should sign the PRF. For patients under the age of 16 where the parent / guardian refuses to sign the form, EAC should be advised and will log it on the call log**. The attending paramedic should give strong consideration for referral to the local safeguarding service and a Datix should be completed.** Where a referral to the local safeguarding team is not made, the reasons for this must be clearly documented on the PRF.

Where there are child safeguarding concerns, the child should be transported to ED. Any child safeguarding concerns should be clearly documented on the PRF and communicated verbally to the receiving clinician at hospital. The PSNI should be made aware via EAC and the guidance offered in the Child Protection Policy / safeguarding pathway should be followed.

13.2 Neutropenic sepsis

Neutropenic sepsis is a potentially fatal complication of cancer treatments, such as chemotherapy. Where a patient who is currently receiving treatment or has received treatment for cancer within the previous 6 weeks becomes unwell, the attending crew MUST ring the patient's cancer centre advice line for support. The crew MUST act on the advice given. Where it is not possible to contact the advice line, the patient MUST be transported to the most appropriate ED.

13.3 Intoxicated patients

Following assessment, it may be appropriate for patients to be discharged to the care of another responsible person. The patient should have a complete assessment that is documented and a copy of the patient report form left with the patient. Once the paramedic has satisfied themselves that the patient has no medical complaint or traumatic injuries, the patient may be left in care of the PSNI or another responsible person. Any patient with a reduced level of consciousness should be transported to the ED.

13.4 Vulnerable adults

Vulnerable adults are those aged over 18 who receive or may need community care services because of a disability, age or illness. They are or may be unable to take care of themselves or protect themselves from significant harm or exploitation. Patients who are under the influence of drugs / alcohol may also be vulnerable. The

attending clinician should have a lower threshold for transporting or referring this group of patients.

13.5 Falls

If a patient has fallen, the paramedic should satisfy themselves that the patient is uninjured and that their mobility is the same as their pre-fall presentation. All patients who have fallen but are uninjured should be assessed using this guidance, and a falls referral made if they meet the inclusion criteria. Patients who have fallen and sustained an apparently minor head injury but who are being treated with anticoagulants and / or combination anti-platelet therapy MUST be transported to the most appropriate Emergency Department

13.6 The elderly

The elderly often present atypically, therefore the paramedic should have a lower threshold for transporting the patient or referring to an appropriate professional.

14.0 Healthcare Professional calls

14.1 Healthcare professionals (HCPs) often request ambulance assistance to transport patients to appropriate facilities. On occasions, the HCP may not have seen the patient and the referral was made based on a telephone consultation. There are times when the paramedic finds that the patient presents differently to what was described to the HCP. It is appropriate for the paramedic to contact the HCP to either confirm the original referral pathway or arrange a new pathway if appropriate. It is not necessary to contact the HCP should the patient require emergency transport to the ED or specialist facility such as the cath lab.

14.2 **If a HCP for example GP, district nurse or other professional has advised a patient to call an ambulance and it is subsequently established that an emergency ambulance was not appropriate. The paramedic MUST then contact the original referrer in order to mutually agree an action plan. Where contact cannot be made with the referring HCP, the patient MUST be transported as requested. If no treatment / assessment is required during transport, it may be appropriate for the paramedic to suggest an alternative means of transport**

15.0 Clinical Support desk

15.1 The clinical support desk (CSD) is staffed by experienced pre hospital clinicians. The role of the CSD is threefold:

1) To undertake patient consultations over the phone and perform a thorough history taking assessment. This is also known as hear and treat / hear and refer.
2) To provide a reassessment of calls that on occasion have been incorrectly graded by the Advanced Medical Priority System (AMPDS)
3) To provide clinical advice to frontline staff and to sign post staff to referral pathways in their local area.

16.0 Communicating revised / New local guidelines

16.1 Many referral pathways and agreements have been established with other health professionals. When each new guideline is agreed / revised, it will be communicated through a range of media such as:

- Newsletters
- Staff memos
- Bulletin on MDT
- C3 messages
- Email
- Intranet
- Clinical Support Officers
- Divisional Training Officers
- Annual refresher training

Appendix A. Examples of patient presentations whereby transport is strongly recommended or clinical advice should be sought.

Airway problems – even if the patient appears well

Breathing problems – if accompanied by significant (red flag) symptoms e/g haemoptysis or abnormal observations

Cardiac chest pain - or any undiagnosed cardiac arrhythmia which results in patient compromise. Please note that a normal sinus rhythm ECG does NOT exclude an underlying cardiac pathology. Anyone with signs or symptoms suggestive of an acute cardiac syndrome MUST be transported to the ED even if the ECG is inconclusive.

Acute confusion

Abdominal pain – unless clear diagnosis evident e.g. UTI

Seizures / fits – first presentation fits, serial fits or eclamptic fits should all be transported.

Falls with suspected fracture – unless below elbow / knee fracture where the patient can manage their pain and have an appropriate means of transport

Acute onset of headache – Consider a sub arachnoid haemorrhage in patients presenting with an acute "thunderclap" headache.

Burns - Partial / full thickness burns over 5% **or** burns to the face / hands / feet / genitals should be transported to an appropriate unit.

Head injuries - where the patient is under the influence of drugs / alcohol and GCS is less than 15/15. Patients being treated with warfarin and / or combination antiplatelet therapy and have sustained a head injury should be treated as a medical emergency.

Children - who have been seen by a health care professional in the previous 24 hours and who are experiencing an exacerbation of symptom's or whose parents remain concerned should be transported to an appropriate facility.

Neutropenic sepsis – patients who are receiving or have received treatment for cancer in the previous 6 weeks become unwell are at risk of developing neutropenic sepsis

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Glossary

AACE – Association of Ambulance Chief Executives

ACA – Ambulance Care Assistant

ACP – Alternative Care Pathways

ASAM – Ambulance Service Area Manager

CSD – Clinical Support Desk

CSO – Clinical Support Officer

CSR – Comprehensive Spending Review

DHSSPS – Department of Health, Social Services and Public Safety

DTO – Divisional Training Officer

EAC – Emergency Ambulance Control

ED – Emergency Department

EMD – Emergency Medical Dispatcher

EMT – Emergency Medical Technician

GP – General Practitioner

HCP – Health Care Professional

HCPC – Health and Care Professions Council

ICV – Intermediate Care Vehicle

JRCALC – Joint Royal Colleges Ambulance Liaison Committee

MIU – Minor Injury Unit

NEWS – National Early Warning Score

NIAS – Northern Ireland Ambulance Service

NICE – National Institute for Health and Care Excellence

PCS – Patient Care Service

PRF – Patient Report Form

PSNI – Police Service of Northern Ireland

RATC – Regional Ambulance Training Centre

RRV – Rapid Response Vehicle

SAI – Serious Adverse Incident

SO – Station Officer

UIR – Untoward Incident Report