North East Ambulance Service NHS
NHS Foundation Trust

Newly Qualified Paramedics working a clinical lead

Document Control Sheet

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1. Scope

This procedure aims to support Newly Qualified Paramedics (NQPs) when working as the lead clinician.

The NQP is expected to operate within NEAS and national clinical practice guidelines, policies and standard operating procedures. This includes seeking senior clinical advice or referral when necessary.

2. Responsibility

2.1 It is the responsibility of the Lead consultant paramedic to provide support, guidance and direction to the Trust in respect of the clinical standards of practice for ambulance staff.

2.2 It is the responsibility of newly qualified paramedics to ensure they adhere to all Trust policies and procedure whilst ensuring that they understand the Health and Care Professions Council (HCPC) requirements, specifically:

- Ensure that they maintain their patient care assessment, diagnosis and treatment skills (as appropriate) in line with their training
- Ensure that their skills in patient care, diagnosis and treatment are in line with their training and skill level

3. PROCEDURE

3.1 Deviation

Deviation in the context of this procedure is defined as any departure from a pre-existing set of instructions or expected standard of care. It is accepted that there will be occasions when it is not possible to comply fully with this procedure. Any deviation should be in the patient’s best interests and must be justified and documented on the clinical record.

3.2 Clinical practice guidelines

Clinical guidelines include, but are not limited to, those provided by the Joint Royal College Ambulance Liaison Committee (JRCALC clinical practice guidelines, the National Institute from Clinical Excellence (NICE) and NEAS issued guidance, including paramedic pathfinder.

NQPs must not deviate from clinical guidance when discharging a patient at scene, without either a senior clinical advice from a paramedic/nurse (band 6) or another appropriate health care professional validating their decision.

It is implicit that when considering deviation that the clinician understands the clinical, physical, procedural and legal implications of deviation from agreed guidelines.

3.3 Medicines

NQPs can autonomously administer medicines under the Human Medicines Regulations 2012. If an NQP wishes to administer these specific medicines outside of JRCALC/trust guidance, then advice must be sought from a senior clinician prior.

It is not legally permissible for any paramedic to deviate from Patient Group Directives.

3.4 Patient refusal

If the patient refuses conveyance or referral to another service and has the capacity to make the decision, then you do not need to seek senior clinical advice prior to discharge. This is applicable to the high-risk patient groups.

You must record the following information:

- Mental capacity assessment is recoded
- The reason the patient requires hospital and the risks of not following this advice (this may be duplicated in the MCA)
- What you advised the patient
- The safety net and worsening symptoms instructions that were provided to the patient
- Who the patient was left in care of
- Non-conveyance paperwork left for the patient
- ePCR signed by the person refusing and a witness (where possible)

The patient requires transport to hospital for further assessment and investigation as there may be a significant underlying condition that we are able to identify. The consequence of not attending could potentially be life-threatening. The patient demonstrate they had capacity and refused against advice. They were instructed to call 999 if worsening symptoms present and follow up with their own GP. Pt left in the care of relative with non-convey form.

For any patient refusing hospital against advice and have demonstrated that they do not have mental capacity, the NQP should contact the CAS to support making a best interest/least restrictive option decision.

3.5 Conveying to hospital

If the intention is to convey the patient to hospital or other health care facility, NQPs will not be expected to contact senior clinical advice.

3.6 Discharging the patient at scene

When considering discharge at scene, clinical validation is required for a specific cohort of patients which is outlined below. The decision to discharge must be made in agreement with the senior clinician and if agreement cannot be reached then the final decision will be the senior clinicians. The clinical discussion section of the ePCR should be completed for all applicable discharges.

3.7 Seeking clinical advice

Advice can be sought from various sources and this may depend on the type of advice required. The following list outlines possible options but is not an exhaustive list:

- Clinical support desk (Specialist paramedics) Tel. 0300 777 1307
- Clinical assessment suite (GP or APP)
- Clinical care manager
- Band 6 paramedic/nurse
- Primary care services (GP, nurse practitioners)
- Mental health services
- Maternity services
- Healthcare facility (Urgent care centre or emergency department)

When these have been utilised the clinical discussion section of the ePCR should be completed.

3.8 High risk patient groups

The patient cohorts outlined below will require senior clinical advice before discharging on scene. These patient groups have been identified due to the complexity of the presenting condition, assessment, previous adverse incident and pitfalls identified.

- High acuity patients
- Children under 2 years
- Older patients over 75 years
- Head injuries
- Recent contact with a healthcare professional within 24hours
- Mental health related crisis
- Maternity related presentation
- Safeguarding concerns
- Transient loss of consciousness

3.8.1 High acuity patients

- Patients with a NEWS2 equal to or great than 4 or a single parameter of 3
- Paramedic pathfinder red outcome

3.8.2 Children under 2 years

- All children under the age of 2

3.8.3 Older patients over 75 years

Any patient over the age of 75 years with one of the following:

- More than 2 chronic conditions
- Suspected underlying infection
- History of trauma (excluding simple falls)
- Medications administered by ambulance clinician

3.8.4 Head injuries

- Any patient that has sustained a head injury where red flags have been identified in JRCALC.

3.8.5 Recent contact with a healthcare professional within 24 hours

- Any patient who has had telephone or physical assessment within 24 hours for the related clinical presentation

3.8.6 Mental health related crisis

- Any mental health related crisis.

3.8.7 Safeguarding concerns

- Any safeguarding concerns for abuse or neglect (this does not include welfare referrals)

3.8.8 Transient loss of consciousness

- Any patient with a confirmed loss of consciousness.

3.9 Patient information and safety netting

Patients discharged on scene must be left with a patient information leaflet as outlined on the appropriate care pathway policy. The worsening symptoms who they should contact if they deteriorate or do not improve must be explained to the patient and documented on the clinical record. Please refer to the Appropriate Care Pathway policy.

3.10 Documentation

A clinical record must be completed for every patient contact as per the clinical records policy. Every effort should be made to share information with the patients GP and consent documented on the ePCR for them. The ePCR is the primary method for paramedics documenting clinical records.

The clinicians name, role and summary of discussion must be recorded on every ePCR.