East Midlands Ambulance Service NHS Trust

Solo Responders Standard Operating Procedure

Links

The following documents are closely associated with this policy:

- Operational Strategy
- Health and Safety Policy
- EOC Deployment policy
- Clinical Strategy

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Version	Date Approved	Publication Date	Approved By	Summary of Changes
1.0	30 November 2012		Operational Governance Group	New SOP
2.0	27 February 2015	05 March 2015	Risk, Safety and Governance Group	SOP combines the following documents • Patients transported by Solo responders • Solo responder selection • Solo responder
2.1				

Contents **Page**

1. Introduction

The aim of the standing operation procedure SOP is to give clear guidance to all staff who undertakes solo responder duties appertaining to this role. It outlines the operational and clinical responsibilities of undertaking this role in line with trust policies and procedures.

2. Objective

To allow staff undertaking these duties to have clear instruction of what is permissible within the remit of solo responding and the clinical assessments required prior to transporting a patient along with staff and patient safety.

3. Scope

This Standard Operational Procedure (SOP) outlines:

- The procedures that should be followed when a solo responder requests backup from a double-crewed ambulance (DCA)

- The type of response that should be requested and the actions to be taken by the solo responder upon arrival of the DCA

- The process for solo responders i.e. CP (Consultant paramedic), FRV (Fast Response Vehicle), and ECP (Emergency Care Practitioner), following a thorough clinical dynamic risk assessment of a patient, to transport the patient in the response vehicle to a care facility

- The necessity for TFRVs (Technician Fast Response Vehicle) to contact the Clinical Assessment Team (CAT) for all referrals or non-transportation. The decision to transport by a TFRV will be the sole responsibility of the CAT clinician assessing the call

This SOP does not apply to the rare occasions where an EMT (Emergency Medical Technician) is responding on a **solo** vehicle. In these cases the EMT should always remain at scene and await a crew for transport.

4. Definitions

4.1 The following definitions also apply

FRV = Fast Response Vehicle
TFRV = Technician Fast Response Vehicle
RRV = Rapid Response Vehicle
ECP = Emergency Care Practitioner
CP = Community Paramedic
EMT = Emergency Medical Technician
EOC = Emergency Operations Centre
CAT = Clinical Assessment team

5. Responsibilities

5.1. Document Owner

The Document Owner is the Director of Operations and the document lead is a Consultant Paramedic. Responsibility to ensure compliance through operational management teams to ensure that all Solo responders are selected and made aware of the SOP

5.3 Locality Managers

It is the responsibility of Locality Managers to ensure that all staff working solo in a substantive or interim role on solo duties are selected in line with this SOP; (please see appendix A). It is essential that all individuals receive appropriate support and training before being deployed in these duties.

5.4 Operational and EOC staff

It is the responsibility of the staff groups affected, specifically Registered Paramedics, Emergency Care Practitioners and all EMAS solo responders and members of staff in EMAS Emergency Operations Centre (EOC), to adhere to this procedure.

5.5 Clinician on scene

It is the responsibility of the clinician on scene to carry out a thorough assessment of the patient and in his/her clinical opinion provide information and request for the most appropriate transfer for the patient. ***Please refer to clinical bulletin 136 reference solo responders EOC update.***

Where there is doubt over the suitability of the patient for transport in a solo response vehicle the clinician on scene has absolute authority over whether or not transport can occur.

Where the decision is taken that due to current unavailability of alternative conveying resources ***the risk of moving the patient within a response vehicle is less than the risk of waiting further at scene*** this should be clearly documented on the patient report form.

5.6 EOC Dispatchers

It is the responsibility of EOC to alert front line staff of any dangers that they may have become aware of whilst taking the 999 calls.

It is the responsibility of all solo responders to ensure that a dynamic risk assessment is carried out prior to entering a scene where there may be a risk to personal safety. If it is not felt safe to enter the scene inform EOC immediately and park a safe distance away with blue lights extinguished and await further instruction. The solo responder should furnish as much information as possible to EOC so they can alert other agencies such as police etc.

6. Procedure for operational back up

6.1 Three grade system for requesting backup

To ensure solo responders are backed up in a timely manner based on patient condition and the urgency of the situation, the guidelines below are to be followed when requesting back up for a DCA.

Three different types of response can be requested: red, amber and green. The individual clinician should use their clinical judgement to ascertain the level of backup required using the guidance below:

Red back up		Request for red back up should be for patients that are time critical and immediate removal to hospital is required. Wherever possible EOC should attempt an 8 minute response but in all instances the first available double crewed vehicle should be allocated.
Amber back up		Request for Amber back up should be for patients that are stable but unwell and requires transporting to hospital as soon as possible. Wherever possible EOC will attempt a 30 minute response by the next available double crewed vehicle which is not required to respond to an higher priority call
Green back up		Green request is for alternative clinical pathway/transport for patients that are stable and non-life threatening. The responder will contact the CAT DESK in EOC and request further assessment by a CAT clinician, once that has been agreed the FRV will leave scene and make themselves available to EOC – CAT will then take over the management of the patient and make appropriate arrangements.

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Green – Back up by next available resource or in agreed timeframe by using card 35.
NOTE Card 35 will be implemented within EMAS by end of Quarter 1 of 2014/15.

6.2 Use of card 35:

6.1.1 This request is to be made in situations that are not life threatening and where the treatment required is not subject to any time constraints. Depending upon the situation, when requesting a green response, the FRV may be able to leave the scene prior to the arrival of the DCA, according to the medical condition, their clinical judgement, appropriate examination, safety netting, and completion of documentation.

6.1.2 When requesting backup from a DCA, the above criteria and grading system must be applied. If a 'green' backup response is needed, card 35 can be used in order to book urgent transport within 2 or 4 hours for patients who do not

require immediate transportation to an emergency department or other medical facility such as MAU.

6.1.3 The solo responder must specify the time frame (2 or 4 hours) within which the patient will require transportation.

6.1.4 If the solo responder believes that the patient's condition and situation do not require them to wait for the arrival of the crew, they will be able to leave the scene and book clear, where clinically safe to do so, making themselves available for further response.

6.2.5 If the responder judges that the patient does need constant clinical monitoring, they should request a red or amber response.

6.3 Arrival of the DCA:

6.3.1 The solo responder does not always need to travel to hospital with the DCA, especially if a Paramedic forms part of the backup crew, or if the arriving crew are able to manage the situation without additional Paramedic support from the FRV. The solo responder should only travel with the crew if necessary, for example when the patient's condition warrants it.

6.3.2 If the solo responder has requested backup in order for the patient to be taken to a hospital or other treatment / assessment centre, and if they judge that they do not need to travel with the crew, the FRV should book clear within 10 minutes of the arrival of the DCA. It is understood that in certain situations this 10 minute time limit may not be possible. Reasons for this could include, but are not limited to, the following situations:

- if the solo responder has requested the backup ambulance as an assessment room to support the privacy and dignity of the patient whilst carry out a detailed examination
- if the crew need additional assistance with moving or lifting the patient
- if it is not clinically safe for the FRV to leave the scene
- where critical safeguarding issues have been identified and need to be passed to the arriving crew

Each situation is therefore to be judged independently.

6.3.3 Once clear, the solo responder should them make themselves available at the earliest opportunity.

7. Procedure for clinical assessment and transport by solo responder

7.1 When a solo responder is deployed to an incident, they, on arrival at scene, will carry out a dynamic risk assessment of the patient's condition followed by a thorough clinical assessment. The responder will initially ask if it possible for the patient to make their own way to hospital. Where this is not possible, if the responder decides that the patient is suitable for transport in the response vehicle following the assessment, and the patient/carer is happy with this decision, they will:

- Immediately contact control to ensure that no other vehicle attends
- Inform control of their decision to transport and that the patient/carer consents to this mode of transport
- Contact the receiving health facility to alert them of the patient imminent arrival if considered appropriate.

7.2 As with all cases alternative referral pathway options should be considered where appropriate

7.3 If the decision is taken that, due to current unavailability of alternative conveying resources, the risk of moving the patient within a response vehicle is less than the risk of waiting further at scene the solo responder should continue as below and document as per responsibilities.

7.4 The clinical assessment of a patient being deemed appropriate for transfer by response car should include a full set of observations including but not limited to:

- Pulse rate and rhythm
- Respiratory rate and depth (including peak flow if asthma symptoms)
- Blood Pressure measurement
- 3/12 lead ECG if appropriate
- Neurological assessment
- Pain Score
- Mental Capacity Act assessment

It is expected that in almost all cases where transport by solo responder is considered the vital signs should be within normal limits.

Where it is not possible to record these observations the documentation should clearly demonstrate why this is the case.

7.5 Patients to be transported to a receiving location by solo response vehicle must be able to walk to the vehicle with minimal assistance and without further deterioration.

7.6 All observation should be recorded on the ECS/PRF clearly stating their findings and the rationale for transporting in the response car must be clear and legibly written on the PRF.

7.7 When the responder is assured that the patient is at **low clinical risk** of deterioration, or that the risk of delaying transport is greater than the risk of remaining on scene any longer, transport by solo response vehicle can be undertaken.

7.8 The patient must be secured by seatbelt in the vehicle and at this point the responder should book en-route to receiving location with control. Carriage of an escort, if necessary, should be agreed and control informed.

7.9 If a child or infant is to be carried this should occur in a suitable car seat for the purpose. If this is not possible the child should not be conveyed in the response vehicle.

7.10 If for whatever reasons the patient deteriorates en route the responder should stop and make the vehicle safe and alert control immediately asking for assistance and treat the patient accordingly. Following the incident they should complete an IR1 outlining what occurred en route and patient outcome along with their decision making process for transporting the patient by response vehicle and flag this immediately with their line manager.

7.11 Under no circumstances should the vehicle be tasked to another call, choose to detour to another call or stop for refuelling etc. whilst the patient is in the vehicle. If the vehicle becomes defective whilst en route the responder should alert control immediately and ask for assistance for the patient before contacting fleet.

7.12 On arrival at the receiving location handover should occur as normal following which the responder should make themselves available for further calls with control.

7.13 The responder must adhere to all aspects of the trust Infection, Prevention and Control policies and manage any potential vehicle contamination as per their contents.

8. Patient inclusion/exception for transportation by solo responder

The chart below is not exhaustive and should be a **guide only**; the clinician's assessment on scene should form the basis of the decision to transport the patient by response vehicle and in all cases the above SOP must be followed

Examples of Mobile patients suitable for transfer by response vehicle following assessment identified in section 6.5 above	Examples of Patients not suitable for transfer by response vehicle following assessment identified in section 6.5 above
• **Minor cuts/lacerations requiring closure** • **Sprains and strains where patient can mobilise safely to the vehicle** • **Minor peripheral upper limb suspected fractures where stable and pain controlled.** • **Small scalp wounds with minor mechanism of injury and GCS 15 throughout** • **Eye problems** • **ENT problems excluding airway obstructions and known infectious respiratory diseases** • **Minor Epistaxis** • **Transfer to Primary Care where patient suitable as per above SOP, has been accepted by a GP, but unable to make own way.** **ALL HAEMORRHAGES MUST BE CONTROLLABLE BY DIRECT PRESSURE AND NOT BE AT RISK OF VEHICLE CONTAMINATION**	• **Chest pain cardiac in origin** • **Abdominal pain with guarding and tenderness** • **Head injury with history of unconsciousness** • **Collapse with history of unconsciousness** • **Unstable diabetic** • **Unstable epileptic** • **Any patient with reduced GCS <15** • **Mental health patients** • **Anyone under the influence of Drugs or significant Alcohol** • **Unstable COPD/Asthma patients** • **Any patient with history of violence or rapid deterioration** • **Patients that pose an IPC risk to the vehicle (incontinence etc.)** • **Patients who have been the subject of an alleged sexual assault**

9. Consultation

Consultation has been via the Operations SOP Working Group.

10. Monitoring Compliance and Effectiveness of the SOP

Monitoring of the SOP will be undertaken by the Assistant Medical Director for effectiveness and compliance through the clinical governance group

Appendix A – Selection process

1.0 Scope

To ensure that all staff selected to work as a solo responder as part of their substantive role have the suitable attributes and experience to carry out this role and receive the support and education required. Staff asked to complete solo duties due to unforeseen circumstances should be supported by the duty Team Leader if they have concerns about working solo and be given a copy of the SOP for guidance.

2.0 Selection Criteria

3.1 Recommendation from their team leader for progression onto solo response.

3.2 Must be a qualified HCPC Registered paramedic able to demonstrate competency and preceptorship.

3.3 Must have successfully completed a clinical supervision (IPR) assessment.

3.4 No More than 3 points on their driving licence and have had no recent blameworthy accidents.

3.5 Must undertake and successfully complete a driving familiarisation and assessment with an accredited driving assessor in accordance with the Trust driving policy and the national competencies. The member of staff would have to be reassessed every five years in line with this policy.

3.6 Complete any additional education required for this role; which may include resuscitation update; patient assessment and essential education.

3.7 No current disciplinary sanctions or live sickness reviews.

Although this process is to recruit the member of staff to operate as a solo responder, the Trust may when operational need dictates crew the individual up to work on a double crewed vehicle.