NHS
South East Coast
Ambulance Service
NHS Foundation Trust

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Date

Email:

Dear,

I am writing in response to your enquiry under the Freedom of Information Act 2000 (FOIA) reference FOI 230349

You requested the following information, please also see our response below:

Under the Freedom of Information Act of 2000, please can you provide me with the following information:

I'm an NQP working for SECAmb from the private sector. I'm hoping you could help me understand the role of ECA's when working alongside clinicians.
The current practice by many clinician's within SECAmb and the private sector, is to allow ECA's to take on the role of clinician by allowing them to complete clinical narratives on PCR's, to attend patients being transferred for ongoing emergency care, and to allow them to hand patients over to clinical staff at hospital.
It seems to me the role of ECA within SECAmb is not well defined, especially in relation to some important areas of practice. To make sure I'm delivering the best patient care possible, please could you clarity the following points.
Should ECA's:
• Be attending and monitoring patients who require ongoing emergency care at hospital?
Please find attached our Trusts Scope of Practice and Clinical Standards Policy, within it we outline the clinical scope of practice of all of our clinical grades who are involved in the delivery of patient contact. We also provide a matrix that identifies who is the 'lead clinician' in any of the clinical compositions that could form a clinical response.
From the attached policy, you will see that an Emergency Care Support Worker (ECSW) is able to undertake monitoring (physiological) of a patient, that being said, when you then consider who is the lead clinician (and in the context of yourself as a Paramedic registrant working alongside the ECSW it is you taking clinical primacy. What this means in practice is that there is a clinical judgement required of you as the lead clinician as to the appropriateness of allowing for an ECSW to attend and monitor patients requiring ongoing emergency care at hospital. Your decision is a personal one, but one that will likely be influenced by the patients presentation, your working impression, if the patient requires active and ongoing treatment and of course your comfort in a non-registrant being the 'attending clinician' and if you feel that they would escalate changing presentation in the patient.

This will of course be subject to clear and open dialogue with your colleague. Where there is doubt, then it would be reasonable and appropriate that you remain directly involved in the ongoing monitoring and care of a patient as the lead clinician.

• Be completing the Clinical narratives on PCRs independently?

As per the answer provided above, the Trust has defined policies and procedures surrounding patient care records. ECSWs are trained in the completion of patient documentation. All clinicians involved in the care of a patient should be recorded on the patient care record and the lead clinician will have primacy over the quality of documentation.

• Be handing over to clinical members of staff/teams at hospital?

ECSWs are taught how to handover patients, as a rule of thumb, whomever is the 'attending clinician' would undertake the verbal handover to a receiving clinician. Where an ECSW conducts this, it can of course be augmented by your additions. The documentation is key, and principle in bullet point two will ensure that correct and appropriate information is included in the documented handover of patients.

1) **Should an ECA, who is not a clinician, be given autonomy to write clinical narratives on a PCR, provided the clinician agrees with what has been documented and is prepared to sign and take responsibility for it? Essentially, should non-clinical staff be writing clinical notes for patients? HCA's in hospital would never do this as they are not clinically trained to do so, however this appears to be acceptable practice in the ambulance service.**

This has been answered as part of bullet point two. The same principle can be said for any non-registrant i.e. AAP/Technician who is not operating as the Lead Clinician as per the Trusts Scope of Practice and Clinical Standards Policy.

2) **Should an ECA, who is not a clinician, be allowed to attend and monitor patients unsupervised, who require ongoing emergency care? If the clinician is driving and not in a position to supervise the ECA or the patient, they have to rely on a non-clinical member of staff to report on the patients condition. The role of an ECA is to assist the clinician, not to assume the role of a clinician, so Is this acceptable practice?**

This has been answered in bullet point one, as registrant you are the lead clinician and therefore take primacy. That being said, it is within the defined scope of practice for the ECSW to undertake a primary assessment and physiological monitoring therefore assuming there is no ongoing care needs that exceed the scope of practice of the ECSW it could be reasonable for the ECSW to continue to 'attend' to the patient.

3) **Should an ECA, who is not a clinician, be handing over a patient who requires ongoing emergency care to clinical staff members at hospital, sometimes to a team of senior clinician's in a hospital RESUS department? Essentially, should non-clinical staff be handing over patients, who require ongoing emergency care, to clinical staff members?**

This has been answered in bullet 3.

Have busy 12 hour shifts over many years created a pattern of working that does not serve the patients best interests?
There is an argument for ECA's being given the opportunity to gain experience and develop their skills, but this should not result in them working outside their scope of practice, and this should never outweigh patient care. In my opinion non-clinical staff members who want to take on the responsibilities of a clinician should train as clinician's. Is it wrong for me think this?
The Trusts Scope of Practice and Clinical Standards Policy clearly defines the roles and responsibilities of any clinical grade working within or for our organisation. At no point should any clinical grade of staff exceed their documented scope of practice, to do so would be inappropriate. It is also important to recognise that for a proportion of our patient encounters, following clinical examination and the forming of a working impression and treatment plan, there may be a requirement for transportation to a receiving destination for a patient who does not require any ongoing clinical intervention (above standard 'monitoring'), this would fall within the defined scope of practice. If the lead clinician is comfortable, it may be both reasonable and practicable for the ECSW to 'attend' the patient encounter.
All clinical grades have responsibilities to their defined clinical scope of practice, as a registrant, a Paramedic would take lead clinician and therefore primacy even if working with an 'AAP or technician'.
The attached ECA scope of practice from Yorkshire Ambulance Service, is the most comprehensive I have seen in relation to the points I have mentioned above. This document highlights in detail how the clinician and ECA should work together on page 5.
It states that an ECA may attend a patient during transport if the patient is clinically stable, requires no ongoing monitoring, and there is no foreseeable deterioration of the patient.
It also states that a PCR should be completed by a clinician, and that a clinician to clinician handover should take place when at hospital.
From what I have seen, the ECA scope of practice within SECAmb does not clarify these points, which may account for the way things are currently working.

With this in mind, Is what we are currently doing in the patients best interests? Should we be doing things differently? And where do I stand in relation to this as a Paramedic?
It is our belief that there are appropriate policies and procedures that provide clarity surrounding the roles and responsibilities of our clinicians. We will always strive for working in the patients best interests. Governance groups and forums exist within the Trust to consider what we do and if we should be doing anything differently.
As a Paramedic you are responsible for meeting the HCPC standards set by the HCPC as your regulator. Similarly you are required to work to your employing organisations policies and procedures. If this is undertaken then you are in good standing as a Paramedic.
Please could you provide a more comprehensive and detailed account of what is acceptable practice for ECAs working with clinician's within SECAmb.

I hope you find this information of some assistance.

If for any reason you are dissatisfied with our response, kindly in the first instance contact Caroline Smart, Head of Information Governance via the following email address:

FOI@secamb.nhs.uk

Yours sincerely

Freedom of Information Coordinator
South East Coast Ambulance Service NHS Foundation Trust