South East Coast Ambulance Service NHS
NHS Foundation Trust

Scope of Practice and Clinical Standards Policy

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Name of originator/ author:	Andy Collen, Consultant Paramedic (Urgent & Emergency Care)
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Review/comments:

Person/ Committee	Comments	Version	Date
Andy Collen	Correction made relating to routes of medicine administration for some grades of staff	V12.00	Oct22
Andy Collen	Updated following consultation ahead of final approval and publication	V11.08	26/5/2022
Kirsty Booth	Reformatted to new template	11.07	28/10/2021
Andy Collen	V11.01 – 11.06 – iterative updates as part of major review and update	V11.06	Oct 2021
Andy Collen	Review	11.0	2020-2021
Andy Collen	Updates: IBIS GP summaries, iGel use	10.01	TBC
Andy Collen	Corrections made (IECR, NQP referral rights, authority for Clopidogrel, front of neck access)	V9.15	June 2018
Andy Collen	Approved at JPF. Minor formatting updates made. Submitted for SMT meeting	V9.14	27/2/18
Andy Collen	Final draft for JPF 27th Feb 18	V9.13	Feb 18
Andy Collen	Draft for 3-week consultation period	V9.12	January 2018
Andy Collen	Updates following policy review workshop held in Jan 18	V9.11	January 2018
Andy Collen	Please note error in version control references for development versions of document. Latest draft now back to 9.09 onwards	V9.10	January 2018
Andy Collen	Commencement of Major Review of Policy Removal of individual appendices and inclusion of skills matrix instead	V10.01 – 10.03	December 2017
Andy Collen	Minor correction to Appendix M regarding medicines mechanism for each stated medicine	V9.09	17th Oct 2017
Andy Collen	Final changes for JPF/SMT (clean version)	V9.05	Sept 17
Andy Collen	Amendments from consultation	V9.04	Sept 17
Andy Collen	Major update to Appendix M	V9.03	Sept 17

	Minor updates to body of policy document, including statement regarding formulary		
Andy Collen	Updated error in Appendix M – added Prochlorperazine	V9.00	Feb 17
Andy Collen	Updates to PTS appendix and review of current version with Asst Company Secretary for publication	V8.01	Jan 17
Andy Collen	Update to Technician appendix to clarify position on ability to use skills from all lower grades	V8.00c	10/10/16
Andy Collen	Changes to clarify discharge arrangements in line with Discharge Procedure. Changes to CCP appendix clarifying supervisory arrangements for CCPPLs	V8.00b	25/4/16
Andy Collen	Further minor clarity relating to discharge of children	V7.00	14/4/16
Andy Collen/CQWG	Minor changes to wording to clarify discharge authority by Technicians CCPs appendix update	V7.00a	18/2/16
Andy Collen	CQWG – changes to paramedic appendix approved Associate Practitioner use of Adrenaline 1:100 reverted to supported decision model	V6.00	27/10/15
Andy Collen	Minor changes to paramedic appendix to support the CPT project	V6.00	15/10/15
Andy Collen	Final version sent for publication	V6.00	
Andy Collen	Updated with KLOE's	V6.00	12/9/15
CQWG	Approval of minor changes to Paramedic appendix to support Community Paramedic programme	V6.00	21/08/2015
CQWG	Approval of changes to appendices	V6.00 (amended)	15/06/2015
Andy Collen	Clarification regarding supervised administration of medicines (ECSW appendix)	V6.00 App 01	27/05/2015
RMCGC	For approval of policy	V6.00	16/03/2015
Andy Collen	Appendix M updated from Medicines Management Lead. Final draft for RMCGC Trainee Paramedic title to Associate Practitioner	V5.06	25/02/2015
Andy Collen	Minor changes required from CQWG.	V5.05	12/02/2015
Clinical Quality Working Group	Recommended for approval at RMCGC	V5.03	3/02/2015
Andy Collen	Change of role title: Trainee Paramedic now Associate Practitioner	V5.03	26/01/2015
Andy Collen	Additional guidance relating to ECSWs and undergrad student paramedics	V5.02	24/12/2014

Andy Collen	Draft version agreed as operational draft – approved by Andy Newton. Agenda item requested at Dec CQWG. Requires ratification at RMCGC	V5.01	19/11/2014
Andy Collen	Inclusion of changes from comments from L&D	V5.00	19/11/2014
Andy Collen	Change AECSW to Trainee Paramedic. Additional information regarding protection of paramedic title	V5.00	18/11/2014
Andy Collen	Development of Advanced ECSW appendix	V5.00	11/11/2014
Dave Wells/Andy Collen	Development of new appendix for Fire Service IECR provision	V5.00	22/07/2014
CQWG	Updates approved to ECSW and Technician appendices	V5.00	
Andy Collen	Changes to Equality Analysis	V5.00	20/11/2013
CQWG	Revision to Appendix M (medicines)	V5.00	12/08/2013
Risk Management and Clinical Governance Committee	Approved	V5.00	04/07/2013
Equality Analysis Engagement and Action Plan	Minor changes to EA statements	V4.04	26/06/2013
Clinical Quality Working Group	For ratification	V4.04	07/06/2013
Medicine Management Sub-Group	For approval of Appendix M	V4.04	20/05/2013
Andy Collen	Updates following comments from SCOT and Medical	V4.04	16/05/2013
SCOT	For information/comment	V4.03	16/05/2013
Andy Collen	Collation of changes	V4.03	15/05/2013
Andy Parker	Additional of Medicines Management Appendix	V4.02	14/05/2013
SCOT	Updates to appendices regarding oxygen use by ECSWs	V4.02	14/05/2013
Wendy Hampson	Updates to PTS Appendices	V4.02	09/05/2013
Andy Collen	Clarification around autonomous use of oxygen	V4.02	08/05/2013
Andy Collen	Change in role title in PTS appendix	V4.01	23/04/2013
Nicola Brooks	Minor amendment to Appendix L regarding DBS and registration	V3.02	13/03/2013
Jane Pateman	Approved by Chair's action due to postponement of CGWG meeting	V3.01	12/02/2013

CGWG	For approval (meeting postponed, comments sought offline)	V3.01	05/02/2013
Andy Collen	Addition of new appendix: 111 Clinical Advisor/ 111 Senior Clinical Advisor	V3.01	29/01/2013
RMCGC	Approved	V3.00	22/10/2013
CGWG tele conf	Approved according to authority to approve changes to appendices	V2.02	22/10/2012
Voluntary Services Department	Updates to CFR appendix	V2.01	15/10/2012
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RMCGC	For approval	V1.06	05/07/2012
Wendy Hampson/Andy Collen	Alterations and additions to PTS Appendices	V1.05	22/06/2012
SPF members	Further clarifications	V1.04	12/04/2012
CGWG	For approval	V1.04	10/04/2012
Staff side representatives	Discussion	V1.03	10/04/2012
Andy Collen	Revisions following SCOT	V1.03	28/03/2012
SCOT members	For comment	V1.02	28/03/2012
Andy Collen	Revisions	V1.01	13/03/2012
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RMCGC	Approved at RMCGC	V0.02	10/11/2011
Clinical Governance Working Group	Approved with minor changes for RMCGC (inc in this version)	V0.01	25/10/2011
Jo Byers	First Draft	V0.01	18/09/2011
Andy Collen	First Draft	V0.01	14/09/2011

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Where Held	Corporate Records Register
Disposal Method and Date	In line with national guidelines

Contents

1 Statement of Aims and Objectives

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to providing clinical care at the highest standard. The Trust also strives to meet changing patient need by ensuring staff and workers (see section 3.1) have the skills, knowledge, and equipment in order to care for our patients/populations confidently and competently.

1.2. The purpose of this policy is to provide clear guidance for all grades of patient-facing staff regarding the scope and breadth of their practice and professional development.

1.3. The policy also defines the standards of care we strive to provide in order to optimise care, reduce risk, and improve the experience of staff in the workplace.

1.4. The main objectives of this document are:

1.4.1. To provide guidance for staff to ensure they practice within clear boundaries and with the correct empowerment to act confidently on behalf of patients.

1.4.2. To provide a framework which demonstrates that our Trust provides staff with the appropriate clinical leadership, authority to act, supervision and education/CPD to meet the needs of our patients.

1.4.3. To define and/or reiterate the standards of clinical care required by the Trust and/or regulatory and statutory bodies (i.e., Health & Care Professions Council, Nursing and Midwifery Council, Medicines and Healthcare products Regulatory Agency, Care Quality Commission).

1.5. This policy is intended to provide clear instruction for staff to follow in the course of their clinical care and will serve as the primary source of information relating to practice against which quality of care is upheld.

1.6. While scope of practice is individual to each member of staff, this document sets the Trust's level of expectation in relation to what that scope of practice should include and not exceed.

1.7. This document contributes to the maintenance of the standards we set ourselves or set by regulators, and those that are required contractually or to evidence national performance standards.

1.8. This document defines standards for staff and seeks to optimise patient outcomes by ensuring staff work within their scope and competency, and to a required quality standard. The policy outlines the importance of promoting a Learning Culture and a Just Culture in our Trust, and how the standards related to scope of practice can be observed in order to uphold patient safety and quality of care, and the experience of our staff in the workplace.

2 Scope

2.1. This document is intended for patient facing staff. Staff working in corporate roles are not deemed to have a scope of practice unless they retain a clinical grade as part of their role or ongoing practice or registrant requirements.

2.2. This policy does not include clinical practice relating to occupational healthcare or wellbeing activities

2.3. This version of the document no longer includes appendices for clinical practice roles in the EOC. Scope of practice of clinicians undertaking Hear & Treat and clinical advice service (CAS) roles is the responsibility of the integrated urgent care team (operations directorate), supported by organisational governance processes.

2.4. For the purposes of this document, the term staff is used but may be interchangeable with other terms such as “clinician” or “responder”.

2.5. This document applies to the following staff or groups of staff:

2.5.1. Directly employed full-time and less than full-time staff

2.5.2. Bank workers

2.5.3. Volunteers in patient facing roles

2.5.4. Co-responders attending 999 calls on behalf of the Trust (including Immediate Emergency Care Responders – IECR)

2.6. Patients within our region may be attended by other agencies which are either outside our governance structures, contracted to us, or work as part of a charitable or voluntary organisation. These organisations are registered with the CQC in their own right and work to their own policy and procedure documents. However, where formal arrangements are in place, SECAmb documents should be adopted or mapped to these organisations and overseen via contractual assurance processes. The following examples are therefore not in scope for this document unless working for us (not exhaustive).

2.6.1. HEMS

2.6.2. Private ambulance providers sub-contracted to the Trust (who work to their own governance outlined in the contract framework with each PAP)

2.6.3. Voluntary Aid Providers, regardless of when working alongside each other at an event (except when the provider is acting as a sub-contractor for SECAmb)

2.6.4. Police Medics

2.6.5. Search and Rescue providers (i.e., Coastguard, Lowland Rescue).

3 Principles

3.1. Staff must not exceed their scope of practice, but also should not fall below the range of essential skills and interventions set within each clinical practice area.

3.2. This document is not intended to be read and followed in isolation. Please refer to all the documents listed in the Associated Documentation and References sections. This is particularly important when, for example, defining authority to refer or discharge patients.

3.3. Scope of practice, clinical standards, professional leadership, and clinical supervision are all interconnected aspects of patient care. Staff should engage in leadership and supervisory activities in order to ensure their practice is optimised and patients receive the best possible care.

3.4. It is the responsibility of each member of staff to raise with their line manager and/or clinical/professional lead any perceived deficiencies or lack of contemporary experience in any practice area, and to ensure that their scope of practice is maintained, and standards upheld. Where relevant, this links to professional requirements for continuous professional development.

3.5. Staff undertaking procedures or interventions under direct supervision must only do so if this will not adversely affect patient care. In circumstances where time critical interventions are needed, the most appropriate person present should be selected to perform this. The experiential learning needs of staff must be balanced against the suitability of performing a supervised skill in a given context and the risk this may pose to the patient.

3.6. Staff are required to provide care at an acceptable standard and this policy describes the interventions required by each grade of staff and assumes baseline competency. Where specific competencies need to be defined, standard operating procedures (or equivalent) will be produced for any specific standards requirements (for example, ECG recognition).

3.7. The Trust has a requirement to monitor practice, and to support staff in order to maintain and promote their scope of practice and clinical standards.

3.8. The Trust is committed to promoting safe and effective care; the management of clinical risk, and the evidencing of a governance-led approach to how it deploys staff who provide direct patient care.

3.9. **Navigating the Scope of Practice & Clinical Standards Policy**

3.9.1. The specific skills and drugs for each grade of clinician can be found in the matrices in the appendices of this document. However, there are guiding principles and standards of proficiency that relate to all clinicians employed by or working on behalf of the Trust. These standards of proficiency are similar to those expected of paramedics by the HCPC and

can be found in the HCPC standards of proficiency document. The following principles relate to the grade at which the individual clinician is working and draws heavily from the HCPC guidelines.

3.10. **Maintenance of skills and standards described in this policy**

3.10.1. The Trust has a robust system for appraising staff performance at all levels and functions within the organisation. The annual appraisal is a yearly plan developed between the member of staff and the line manager. The action plan reflects learning and development needs for the year ahead and provides a platform to address concerns over competence and confidence. Appraisal should be part of management and clinical supervision and this in turn is reflected in requirements for staff who hold a professional registration (for example, with the HCPC).

3.10.2. Certain grades/types of staff are entitled to protected training time as defined in specific policy, national policy/guidance, or job description.

3.10.3. Staff are required to understand the standards of clinical care required as either terms of their continued employment and/or prescribed through a professional regulator.

3.10.4. Where competent clinical practice is a requirement of a role, or a professional registration is a requirement of a role, there are no concessions made where clinical practice may not be part of the day-to-day role (i.e., Response Capable Manager). All staff must remain competent at the clinical grade they work at.

3.11. **Failure to work to the required scope of practice or whose clinical standards are below the minimum level.**

3.11.1. Clinicians who fail to work to the required scope of practice or clinical standard fall into one of three categories:

3.11.1.1. Inability due to lack of support, supervision, training, and education (including update training to maintain competency). In this case, the Trust must ensure that the individual receives the relevant training, education, and support to enable them to work to the required level.

3.11.1.2. Unwilling to, despite either receiving or being offered the required education and training.

3.11.1.3. Have knowingly or unknowingly carried out procedures, actions or processes that are outside the scope of practice.

3.11.2. The Trust embraces a just/learning culture and embraces the importance of understanding errors and mistakes in the context of complex sociotechnical healthcare systems. Errors are the starting point of investigations and not the outcome. In some rare circumstances, there may be a requirement to consider using the disciplinary procedure and/or capability procedure. Each case will be independently reviewed and the approach to learning and resolution developed on a case-by-case basis.

3.11.3. Procedures intentionally or wilfully/negligently carried out beyond the scope of practice may be considered as assault, whether consent has been obtained or not, and the Trust may be required to report incidents of this nature to the Police.

3.12. **Referrals to Professional Regulators**

3.12.1. Where staff hold a professional registration, the Trust may on occasion be required to make referrals where practice concerns arise. This will only be done at the point of the establishment of facts regarding practice concerns. Referrals are not made routinely on receipt of a complaint or clinical error. Regulators require objectively reported practice concerns in order to begin Fitness to Practice proceedings, and the Trust will seek to minimise referrals to only those where the regulators guidance is met regarding when to refer.

3.12.2. The ambulance sector and the paramedic profession have a very high rate of self-referral to the Health & Care Professions Council. Trust staff are advised to speak to a Consultant Paramedic, Professional Standards Manager or Practice Development Lead prior to making a self-referral.

3.12.3. Local managers must not advise staff to self-refer routinely and should seek the advice of a PSM or Consultant Paramedic when dealing with professional practice or conduct issues.

3.12.4. Referrals may also be associated with restrictions in clinical practice. Please refer to this procedure when considering the need for restrictions.

3.13. **Adjustments for Staff Undertaking Education and Training**

3.13.1. Staff in certain clinical grades may be subject to amendments to the scope of practice listed in Appendix A. **Clinical Education Department** will provide details of any amendments or restrictions on commencement of the course.

3.13.2. Upon successful completion of a programme of study or period of preceptorship, amendments to your scope of practice will be lifted. Staff will then work to their full defined scope of practice.

3.14. **Amending the scope of practice**

3.14.1. The **Professional Practice Group** is authorised to approve the addition, removal and amendment of the individual skills and interventions on the matrices in Appendix A and M. This will allow more rapid updating (fast-tracking) of the document but does not subvert the Trust process for policy approval.

3.14.2. Where changes are made and approved, the policy will be re-approved in accordance with the Trust's Policy on Policies. Where possible, for minor changes, this will be done via the Fast-Track process.

3.15. **Clinical accountability:** Registered clinicians must work to their professional code and standards published by their regulators (Health and

Care Professions Council, Nursing and Midwifery Council, General Medical Council).

3.16. Clinicians are responsible for providing high-quality, professional care on behalf of the Trust, and are accountable to the Medical Director and the Consultant Paramedics accordingly, (and their professional regulators where applicable).

3.17. **All Trust staff must:**

3.17.1. Practice within the legal and ethical boundaries of their work role.

3.17.2. Practice in a non-discriminatory and culturally sensitive manner.

3.17.3. Maintain confidentiality.

3.17.4. Obtain consent and/or act in the patient's best interest.

3.17.5. Exercise a duty of care.

3.17.6. Know the limits of their practice and knowledge and know when to seek advice and guidance from senior clinicians.

3.17.7. Maintain their level of knowledge and their fitness to practice.

3.17.8. Undertake career-long self-directed learning using reflection to improve their practice.

3.17.9. Prioritise safe and effective delivery of patient care and facilitate the learning needs of clinical staff when it is appropriate to do so.

3.17.10. Undertake development in order to maintain skills and knowledge in line with developments and changes in the role.

3.18. **Inter-disciplinary relationships:** All Trust clinicians should:

3.18.1. Know the personal scope of their practice and be able to make referrals to senior clinicians where appropriate.

3.18.2. Be able to work in partnership with other clinicians and professionals, patients and their relatives and carers.

3.18.3. Ensure that time-critical interventions are performed by the most appropriately skilled member of the team,

3.18.4. Work effectively as part of a multi-disciplinary team and in partnership with other professionals.

3.18.5. Understand the need for effective communication throughout the care of the patient. This may be with client or user support staff, with patients, clients, and users, and with their relatives and carers.

3.19. **Identification and assessment of health and social care needs:** All Trust clinicians should, within their scope of practice:

3.19.1. Be able to gather appropriate information.

3.19.2. Be able to use appropriate assessment techniques.

3.19.3. Be able to analyse and evaluate the information collected.

3.20. **Knowledge, understanding and skills:** All Trust clinicians should, within their scope of practice:

3.20.1. Know the key concepts related to their level of clinical practice.

3.20.2. Understand the need to establish and maintain a safe practice environment.

3.21. **Core principles of clinical standards:** Staff must practice applying the following principles.

3.21.1. Assume patient autonomy and capacity. Always seek consent from patients where capacity or consciousness allows. Respect and follow all valid advanced directives of care.

3.21.2. Do no harm to your patients. For instance, be minimally invasive; be thorough with checking medicines, and preserving dignity. Follow your scope of practice and do not exceed it.

3.21.3. Allow no harm to come to your patient. Be your patients' advocate to prevent drug errors or poor practice. Promote outcomes by ensuring your treatment for primary problems do not lead to secondary illness (e.g., infection from poor aseptic technique or skin ulceration from inappropriate immobilisation on a spinal board).

3.21.4. Staff must follow closely any standard of care from their professional regulator.

3.22. **Occupation Health Support Under Specific Circumstances**

3.22.1. This policy covers clinical practice (patient facing work). However, in response to exceptional circumstances, such as during a pandemic, clinical staff may be asked to undertake occupational health related tasks (such as undertaking blood sampling or administering vaccines).

3.22.2. Clinical staff undertaking clinical interventions, such as venepuncture, on colleagues as part of agreed escalation measures will be authorised to do so by the Executive Medical Director and Executive Director of Quality and Safety.

3.22.3. Staff must only practice skills which they have evidence of contemporary competency in and have practiced within the last 12 months. Staff whose competency has lapsed may be asked to support specified support tasks following refresher training.

3.22.4. Registered staff who wish to undertake this work may have the opportunity to undertake training in specific skills (such as venepuncture).

3.22.5. Tasks such as venepuncture and swab sampling may not require a professional registration. Where staff have a parallel qualification (for example, as a phlebotomist) the trust can deploy these individuals for periods of duty in that role (rather than their usual trust role). Paramedics (and other registrants) who have previous or current competency to undertake sampling will be specifically authorised to carry out sampling under their core registration and in addition to their existing scope of practice (and therefore bound by the HCPC codes of conduct and competency).

3.22.6. The trust will indemnify staff undertaken the specified tasks during the period stated (i.e., start and finish dates within a pandemic period).

3.22.7. Skills practiced while undertaking occupational health tasks will not form part of the substantive patient-facing scope of practice and may only be carried out according to the authority provided at the time.

3.22.8. Staff will practice to a specific role brief while working on occupational health sampling periods of duty. For non-registrants, this will serve as an alternative job description while undertaking sampling shifts. For registrants, the document will be used to describe the work to be undertaken as an appendix to their core registered role.

3.22.8.1. The Health and Care Professions Council (HCPC) are supporting registrants who are being asked to undertake non-cores which support the Covid19 pandemic. The trust senior clinical leadership team will also provide professional support to staff undertaken sampling roles.

4 Definitions

4.1. **Scope of practice** defines the boundary within which a clinician can operate. It describes the procedures, actions and processes that are expected of each grade of clinician.

4.1.1. When referring to scope of practice, this document specifically means the scope of practice expected of staff working for, or on behalf of, the Trust, either as an employee or another agent (e.g., Co-responders or Community First Responders); from herein will be referred to as “staff”.

4.1.2. Air ambulance, BASICs charity and private providers are not in scope for this document, however contractual requirements may be based upon this document.

4.2. **Clinical Standards** define the attributes required to deliver safe, effective, and high-quality care. To illustrate the difference between scope of practice and clinical standards, intravenous cannulation is in the paramedic scope of practice but must be carried out to a high level of clinical standard, including for example, obtaining consent, applying aseptic technique, communication, and documentation.

4.3. **Medicines Formulary.** Appendix M of this document lists the medicines authorised for possession and use by Trust staff. Please note that

appendix M is not the Trust formulary but is taken from the Trust's official published formulary. Every effort is made to keep appendix M up to date, but changes to the formulary may supersede this document. Staff will be made aware of any changes to the formulary and subsequent authorisation in this document.

5 Responsibilities

5.1. The **Chief Executive Officer** has ultimate responsibility for patient care.

5.2. The **Executive Medical Director** has executive responsibility for Scope of Practice and Clinical Standards.

5.3. The **Consultant Paramedics** are responsible for overseeing the policy on a day-to-day basis, promoting and upholding clinical standards.

5.4. In the operational setting, responsibility will lie with **Operational Team Leaders** (or equivalent), supported by **Practice Development Leads**/**Professional Standards Managers** (or equivalent) to oversee, and ensure that staff work in accordance with this policy.

5.5. **All Trust staff** are responsible for working to the scope of practice and clinical standards commensurate to their clinical grade. For staff who hold a professional healthcare registration, the standards expected of the professional regulator are automatically also adopted by the Trust

5.6. Within all areas of scope practice and clinical standards, **all staff** will adhere to the following areas:

5.6.1. Safeguarding

5.6.2. Mental capacity

5.6.3. Infection prevention and control

5.6.4. Medicines Management

5.6.5. Information Governance and Caldicott guardianship

6 Competence

6.1. In order to practice in any of the roles described in the appendices, staff must have completed an approved programme of education and training which is reflected in their role title.

6.2. In addition, to work at the level of paramedic/nurse and above, clinicians must be registered professionals with the appropriate body for their role.

7 Monitoring

7.1. This policy will be monitored by the Clinical Standards Group.

7.2. The **Consultant Paramedics**, supported by **Operations Managers** will be responsible for ensuring adherence to the policy by reviewing internal reporting systems.

7.2.1. This may include reports received via Patient Advice and Liaison Service (PALS), DIF1 incident reports or verbal reports from staff.

7.3. Any non-compliance or deviation from this policy that results in an adverse outcome for a patient will be dealt with in accordance with the Incident Reporting & Investigation Manual and referred to the Professional Standards Department.

8 Audit and Review

8.1. The policy document will be reviewed every three years; or earlier if required due to change in local/national guidance and/or policy; or as a result of an incident that requires a change in practice.

9 Associated Documentation

9.1. Referral, Discharge and Conveyance Policy

9.2. Discharge Procedure

9.3. Referrals Procedure

9.4. Conveyance, Handover and Transfers of Care Procedure

9.5. Paramedic Practitioner Programme Core Competency Performance Criteria and Clinical Portfolio Document.

9.6. Capability Policy.

9.7. Disciplinary Policy.

9.8. Community First Responder Policy

9.9. IECR Memorandum of Understanding

9.10. Recruitment & Selection Policy.

9.11. Medical Devices Management Policy.

9.12. Risk Management Training Procedure.

9.13. Job Descriptions for roles.

9.14. Infection Prevention and Control Policy and Manual.

9.15. Clinical Supervision Policy

9.16. Health & Safety Policy

9.17. Minimal Moving and Handling Policy

9.18. Medicine Management Policy documents (including all associated Standard Operating Procedures (SOP))

9.19. Policy for the Resuscitation of Adult and Paediatric Patients (including DNACPR)

9.20. Social Media Policy

9.21. Clinical Preceptorship Procedure

9.22. Anti-fraud and bribery policy

10 References

10.1. Joint Royal Colleges Ambulance Liaison Committee (JRCALC)

10.2. Health Care and Professions Council standards documents

10.3. Nursing and Midwifery Council code and standards documents

10.4. General Medical Council: Standards Guidance for Doctors

10.5. College of Paramedics Career Framework (2017)

10.6. Policing and Crime Act (2017) (Duty to collaborate)

11 Equality Analysis

11.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

11.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

Name of author and role	Andy Collen, Consultant Paramedic		
Directorate	Medical	**Date of analysis:**	28th Feb 2022
Name of policy being analysed	Scope of Practice and Clinical Standard Policy		

Names of those involved in this EA	Andy Collen

1. Trust policies and procedures should support the requirements of the Equality Duty within the Equality Act:	• Eliminate discrimination, harassment and victimisation; • Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; • Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.	In submitting this form, you are confirming that you have taken all reasonable steps to ensure that the requirements of the Equality Duty are properly considered.

2. When considering whether the processes outlined in your document may adversely impact on anyone, is there any existing research or information that you have taken into account?	For example: • Local or national research • National health data • Local demographics • SECAmb race equality data • Work undertaken for previous EAs	This policy reflects the scale and scope of clinical care for patients based on the different grades of clinician deployed.

3. Do the processes described have an impact on anyone's human rights?	No. The policy supports correct and appropriate care for our patients

4. What are the outcomes of the EA in relation to people with protected characteristics?			
Protected characteristic	**Impact** Positive/Neutral/Negative	**Protected characteristic**	**Impact** Positive/Neutral/ Negative
Age	Neutral	Race	Neutral
Disability	Neutral	Religion or belief	Neutral
Gender reassignment	Neutral	Sex	Neutral
Marriage and civil partnership	Neutral	Sexual orientation	Neutral
Pregnancy and maternity	Neutral		

5. Mitigating negative impacts:
If any negative impacts have been identified, an Equality Analysis Action Plan must be completed and attached to the EA Record. A template for the action plan is available in the

Equality Analysis Guidance on the Trust's website. Please contact inclusion@secamb.nhs.uk for support and guidance.

Protected characteristic:	N/A	Issue identified:		
Action required:				
Action lead:				
How will impact/outcome be measured?		Timescale:		
Resolution of actions:				

Protected characteristic:	N/A	Issue identified:		
Action required:				
Action lead:				
How will impact/outcome be measured?		Timescale:		
Resolution of actions:				

EA Sign off	
EA checkpoint (Inclusion Working Group member, preferably from your Directorate)	Richard Quirk (Deputy Medical Director)
By signing this, I confirm that I am satisfied the EA process detailed on this form and the work it refers to are non-discriminatory and support the aims of the Equality Act 2010 as outlined in section 1 above.	
Signed: Richard Quirk	Date: 24th March 2022

Appendix A: Skills Authorised for use, by Clinical Grade/Role

Key:

	Full authority (no restriction)
	Restrictions apply (denoted by variable and letter in key columns)
	No authority given for stated skills/intervention

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR	IECR	Emergency Care Support Worker	Associate Practitioner/AAP	Technician/ Advanced Technician	Newly Qualified Paramedic	Paramedic	Paramedic Practitioner	Critical Care Paramedic	Consultant Paramedic*	Doctor*
				*Refer to scope of specialism										
Types of calls attended	All Calls Restricted list	A R		R	R	A	A	A	A	A	A	A	A	A
Mode of response	Routine Emergency/All	R E	Ref 1	R		E	E	E	E	E	E	E	E	E
Skills														
Primary Survey														
Secondary Survey														
Intimate examinations & interventions	Restricted Unrestricted	R U	Ref 2	R	R	R	R	R	U	U	U	U	U	U
Medicines administration			Policy											
	Just in Case		Ref 3											
	Administer Prescribed & dispensed medicines		Ref 4											

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR	IECR	Emergency Care Support Worker	Associate Practitioner/AAP	Technician/ Advanced Technician	Newly Qualified Paramedic	Paramedic	Paramedic Practitioner	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	Encourage/ remind patients to take own prescribed and dispensed medicines		REF 5											
Ventilation and Airway Management														
Airways adjuncts/ techniques	Oropharyngeal airway													
	Nasopharyngeal airway													
	Supraglottic Airway Devices													
	Endotracheal Intubation (adult)	A - Requires evidence of initial training							A	A	A		*	*
	Endotracheal Intubation (paed)												*	*
	Laryngoscopy (and use of Magill forceps) for FBOA.													
	Needle Cricothyroidotomy													*
	Surgical Airway (Front of Neck Access – FONA)												*	*
	BVM (Adult) Lone and 2 persons													

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR	IECR	Emergency Care Support Worker	Associate Practitioner/AAP	Technician/ Advanced Technician	Newly Qualified Paramedic	Paramedic	Paramedic Practitioner	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	Pocket mask for paeds													
Suction														
Other interventions	Orogastric tube												*	*
	Nasogastric tube												*	*
	Needle thoracentesis (anterior approach)													*
	Needle thoracentesis (lateral approach)	A - Requires evidence of training							A	A	A		*	*
	Open Thoracostomy												*	*
Vascular Access														
	Peripheral intravenous access													
	External jugular access	A - Requires evidence of training							A	A	A		*	*
	Humeral intraosseous	A - Requires evidence of training							A	A	A		*	*
	Tibial intraosseous													
	Femoral intraosseous	A - Requires evidence of training							A	A	A		*	*
Routes Of Medicines Administration														

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR	IECR	Emergency Care Support Worker	Associate Practitioner/AAP	Technician/ Advanced Technician	Newly Qualified Paramedic	Paramedic	Paramedic Practitioner	Critical Care Paramedic	Consultant Paramedic*	Doctor*
			Policy											
	Oral													
	Sublingual													
	Buccal													
	Intranasal		Ref 7 (non par POMs)											
	Inhaled													
	Rectal													
	Sub-cutaneous	R = Glucagon only					R	R						
	Intramuscular													
	Intravenous													
	Intraosseous													
	Preparation of parenteral medicines					Exc' CDs	Exc' CDs	Exc' CDs						
Referral and Discharge Rights														
Referral rights	Primary Care	Full (F) Supported (S) None (N)	Ref 8 - AAP/Tech & NQP	N	N	N	S	S	F	F	F	F	F	F
	Secondary Care	Full (F)		N	N	N	S	S	S	F	F	F	F	F

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR	IECR	Emergency Care Support Worker	Associate Practitioner/AAP	Technician/ Advanced Technician	Newly Qualified Paramedic	Paramedic	Paramedic Practitioner	Critical Care Paramedic	Consultant Paramedic*	Doctor*
		Supported (S) None (N)												
	Tertiary Care	Full (F) Supported (S) None (N)		N	N	N	S	S	S	F	F	F	F	F
	Referral of patients aged under 1 year													
Discharge Rights	Discharge at scene (all grades encouraged to seek joint decision making)	Full (F) Supported (S) None (N)	Ref 8 - AAP/Tech & NQP	N	N	N	S	S	S	F	F	F	F	F
	Discharge of patients aged under 1 year	*With evidence of training										*		
Conveyance (unplanned and/or non-HCP calls)	Secondary Care	Full (F) Supported (S) None (N)		N	N	F	F	F	F	F	F	F	F	F
	Tertiary Care	Full (F) Supported (S) None (N)		N	N	S	S	S	S	S	F	F	F	F
	Delayed Conveyance	R = When on SRV only		N	N	N	R	R		F	F	F	F	F
Diagnostics/Observations														

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR	IECR	Emergency Care Support Worker	Associate Practitioner/AAP	Technician/ Advanced Technician	Newly Qualified Paramedic	Paramedic	Paramedic Practitioner	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	Automated Blood Pressure													
	Manual Blood Pressure													
	Pulse Oximetry													
	Capnography													
	Blood glucose	When under direct supervision	Ref 10			Ref								
	ECG monitoring													
	12 lead ECG acquisition													
	12 lead ECG interpretation	R = Shockable rhythms, STEMI, and normal sinus rhythm	Ref 11			R	R	R						
	Peak flow		Ref 12											
Basic Chest Examination	Inspection, Palpation and Auscultation to guide treatment													
Full Chest Examination (in line with physical	Inspection													
	Percussion													
	Palpation													

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR	IECR	Emergency Care Support Worker	Associate Practitioner/AAP	Technician/ Advanced Technician	Newly Qualified Paramedic	Paramedic	Paramedic Practitioner	Critical Care Paramedic	Consultant Paramedic*	Doctor*
assessment module completion)	Auscultation													
Basic Abdominal Examination	Inspection, Light palpation to guide treatment.													
Full Abdominal Examination	Inspection													
	Auscultation		Ref 13											
	Percussion													
	Palpation	R = light palpation only unless trained					R	R						
Neurological assessment	FAST. Gross sensation, sight, gait abnormalities		Ref 14											
	Cranial Nerve exam													
	Dizziness assessment		Ref 14				R	R						
Thermometry	Tympanic													
	Infrared													
	Oesophageal													
Otoscope													*	
Ophthalmoscope													*	
Ultrasound													*	*

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR	IECR	Emergency Care Support Worker	Associate Practitioner/AAP	Technician/ Advanced Technician	Newly Qualified Paramedic	Paramedic	Paramedic Practitioner	Critical Care Paramedic	Consultant Paramedic*	Doctor*
Recognition of Life Extinct (ROLE)	Following commencement of life support													
Recognition of Life Extinct (ROLE)	As per JRCALC guidance for conditions incompatible with life													
Treatments/Therapies														
	Automated Defibrillation													
	Defibrillation (Adult)		Ref 15											
	Manual Defibrillation (Paed)		Ref 15											
	Cardiac Pacing													
	Synchronised Cardioversion													
Wound care *(definitive or intermediate wound care. This does not include the immediate management of acute wounds to address bleeding)*	Local anaesthesia	If trained (T)	Ref 16										*	
	Examination													
	Cleaning													
	Closure (Mepitel/ Steri-strip)													
	Closure (glue)	R = GATSO								R			*	
	Closure (sutures)	If trained (T)											*	
	Dressing	Requires advice (R)		R	B	R								

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR	IECR	Emergency Care Support Worker	Associate Practitioner/AAP	Technician/ Advanced Technician	Newly Qualified Paramedic	Paramedic	Paramedic Practitioner	Critical Care Paramedic	Consultant Paramedic*	Doctor*
		Basic 1st Aid only (B)												
Critical Haemorrhage	Tourniquet													
	Pressure dressing													
	Haemostatic agents/ dressings				MTFA only									
Spinal Immobilisation & fracture management														
	Use of the spinal decision tool		Ref 17											
	Encourage self-extrication and self-mgmt.	Requires support/ supervision (S)					S	S						
	Triple Immobilisation													
	Manual Inline Stabilisation													
	Traction splint													
	Pelvic binder				Assist only									
	Vacuum splint													
	Orthopaedic manipulation		Ref 18										*	*
Escorting Patients after medicines administration														
	Escort patient after receiving opioid		Ref 16											

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR	IECR	Emergency Care Support Worker	Associate Practitioner/AAP	Technician/ Advanced Technician	Newly Qualified Paramedic	Paramedic	Paramedic Practitioner	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	Managing IV fluid infusion													
	Escort patient after receiving benzodiazepine or other form of sedation		Ref 16											
	Escort patient after receiving ketamine from a CCP	As per clinical instruction										N/A		
Safeguarding Referrals														
	Child safeguarding referrals				Own process									
	Adult safeguarding referrals				Own process									
	PREVENT referrals				Own process									
Miscellaneous														
	Falls referrals													
	Hypoglycaemia referrals													
	Access to shared care plans													
	GP Summaries													

Appendix B: Reference Information from Appendix A

Reference Number from Appendix A	Title	Definition
1	Driving Standards Policy	Please refer to the Driving Standards Policy for information about modes of response and authority to use trust vehicles and exemptions
2	Intimate examinations & interventions	ALL grades of staff are authorised to undertake examinations and interventions where clinically indicated in an emergency. Intimate examinations should take place based on the presenting complaint and the patient's health history. Intimate examinations should not be carried out routinely and/or in the absence of a relevant clinical indication. Intimate examinations Visualising and/or palpating/manipulating intimate areas which include genitalia, rectal area, and breasts. • Visual inspection to establish injuries/blood loss and requirement for interventions • To facilitate administration of PR medicines (i.e., Misoprostol or Stesolid) • To establish progress of labour are restricted to immediate life-saving interventions (i.e., stopping bleeding), or where paramedics can administer medicines via the rectal route. Intimate Interventions Insertion of finger or hand into vagina or introducing medicines into vagina or rectum. • Bimanual compression of uterus using internal and external manoeuvre • Replacement of umbilical cord into vagina (during cord prolapse) • Removal of posterior arm in shoulder dystocia Training and education Authority to undertake intimate examination and intervention is only applied following the trust-approved training programme overseen by the Consultant Midwife.

Reference Number from Appendix A	Title	Definition
3	Just in Case Medicines	Patients who are known to be within the palliative or the end of their life phase of illness are sometimes issued anticipatory prescriptions, commonly known as "just in case" medicines. These are often strong controlled medications, such as painkillers or sedatives which may be familiar to SECAmb clinicians but are often prescribed at higher dosages. SECAmb issued medicines cannot be used to fulfil a prescription and therefore our medications must not be left with the patient. Only medicines dispensed to the patient via a pharmacy should be given when following an anticipatory prescription (just in case) prescription chart.
4	Prescribed and Dispensed medicines	Healthcare professionals should, where competent to do so, administer any prescribed medicine that has been dispensed to them by a pharmacy. Where SECAmb staff carry stocks of medicines for use via PGD, these stocks cannot be used to supply further medicines where a prescription as run out. Dispensing can only be done by a pharmacist.
5	Patients own medicines	Patients should be encouraged to be concordant with their medicines. Where staff come across a patient who is not concordant over a long period of time, they should be referred to the GP (or specialist team) for a medication review. Patients who have missed a single dose due the circumstances of their 999 call (i.e., fall) they should be encouraged to recommence their medication where it is safe to do so. Staff must discuss with a PP or the patients GP where there is any uncertainty regarding taking a missed dose (for example, proximity to food, time of day, proximity to subsequent dose).
6	Routes of administration	These routes apply only to medicines authorised for use by trust staff. These may either be supplied by the trust or be medicines dispensed to patients and which may be given by trust staff (i.e., JIC meds, adrenaline autoinjector)
7	Intranasal Medicines	The only medicine that can be given via the intranasal route is Naloxone, which cannot be used under an exemption of the Human Medicines Regulations (2012) in Schedule 19. This exemption applies only to parenteral medicines (injected) and therefore cannot be given by non-parenteral routes such as intranasal. Staff authorised to give naloxone can only do so via IM injection.

Reference Number from Appendix A	Title	Definition
8	Referrals for Associate Ambulance Practitioners, Technicians and Newly Qualified Paramedics.	Referral and Discharge by these groups of staff is authorised but must be done with the support of a senior colleague. The exception to this is where the patient is has an obvious self-limiting condition and/or clearly uninjured. Examples of self-limiting conditions: • D&V with clear history (i.e., affecting other family members) and no sinister comorbidities • Coryzal symptoms lasting less than 10 days Example of conditions which are **not** self-limiting • Chest pain • Breathing difficulties • Limb deformity
10	Blood glucose monitoring by NET vehicles	There is an exception to the guidance regarding ESCW double crewing a DCA regarding taking and recording blood glucose. This may be done when working as a crew on a NET vehicle as directed by the clinician requesting transport (and reporting back results).
11	ECG Interpretation	'Paramedics should be competent in the recognition of commonly encountered abnormal ECGs (including but not limited to): • Sick sinus, • Atrial Fibrillation and Atrial flutter, • AV nodal, bundle branch and fascicular blocks, • Long QTc, • Brugada types 1 and 2, • Wolff-Parkinson-White, • Premature Ventricular Contractions and Ventricular escapes), Staff may, depending on authority, refer/discharge based on the ECG and clinical assessment (observe best practice – see Referral and Discharge Procedures)'

Reference Number from Appendix A	Title	Definition
12	Peak flow	Staff must ensure current Trust, local and/or national guidance is followed regarding the use of peak flow meters during the Covid 19 pandemic, or periods requiring suspension of aerosol generating procedures.
13	Abdominal Assessment	Examining abdomens can be hazardous and therefore is restricted to those trained to undertake a full abdo exam, including deep palpation. Other elements of the abdominal examination should be undertaken, and elements omitted should be documented.
14	Neuro exam	Technicians, APs, and AAPs must consider central nervous system causes of dizziness and seek clinical pathways decision-making support.
15	Manual defibrillation	Manual defibrillation is allowed for any scope in paediatric patients for the purposes of dose attenuation. In adults only paramedics may use manual mode.
16	Escorting patients given Opioids or Benzodiazepines	Non-paramedics may escort patients who have received IV/IO doses of opioids or benzodiazepines. This would most commonly be relating to inter-facility transfers, and after the patient has been monitored in the emergency department.
17	Spinal clearance and/or management	All clinicians should use the Trust's spinal decision tool to determine whether spinal precautions are necessary. Thresholds will vary depending on qualification, experience and training and clinician are encourage to share decisions where appropriate.
18	Orthopaedic Manipulation	Where evidence of training exists, NQP and Paramedics may reduce fractures where distal circulation is threatened. Where evidence of training exists, PPs may also reduce patella dislocations and radial head subluxation.
	Doctors and Consultant Paramedics (*)	Skills used by doctors and consultant paramedics are limited to specialist background qualification/speciality (i.e., PP/CCP, PHEM)

Appendix C: Clinical Grade Crewing and Lead Clinician Matrices

This table shows which staff grades can work with other grades in an operational, patient facing setting. Unplanned, on-day requirements to deviate from this matrix must be agreed with the Strategic Medical Advisor (SMA) on-call.

	Non-clinical Driver	ECSW <3 months	ECSW >3 months	TAAP	AAP1	AP	AAP2 or Technician	NQP <150 hours	NQP 150-300 hours	NQP >300 hours	Paramedic (all grades)	SRV
Non-clinical Driver	NO	NO	NET (5)	NET (2)	NET (2)	YES	YES	NO	NO	NET (7)	YES	NO
ECSW <3 months	NO	NO	NET (5)	NO	NO	YES	YES	NO	NO	NET (7)	YES	NO
ECSW >3 months	NET (5)	NET (5)	NET (5)	NET (2)	YES	YES	YES	NO	NO	YES	YES	NO
TAAP	NET (2)	NO	NET (2)	NET (2)	NET (2)	NET (2)	YES	NO	NO	YES (6)	YES	NO
AAP1	NET (2)	NO	YES	NET (2)	YES	YES	YES	NO	NO (1)	YES	YES	NO
AP	YES	YES	YES	NET (2)	YES	YES	YES	NO	NO (1)	YES	YES	NO (3)
AAP2 or Technician	YES	YES	YES	YES	YES	YES	YES	NO	NO (1)	YES	YES	NO (4)
NQP <150 hours	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	NO
NQP 150-300 HRS	NO	NO	NO	NO	NO (1)	NO (1)	NO (1)	NO	NO	NO (1)	YES	NO
NQP >300 hours	NET (7)	NET (7)	YES	YES (6)	YES	YES	YES	NO	NO (1)	YES	YES	NO
Paramedic (all grades)	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES

Notes

(1) NQP 150-300 hours should work with a Paramedic - this may be changed to facilitate on the day staffing issues however this should be avoided where possible and for no more than 25% of their hours.

(2) TAAPs/NQAAPs may work together in any combination as a NET crew if one of the crew is an internal AAP with a previous ECSW/AP qualification - however this should be avoided where possible and for no more than 25% of their hours. They may work together on overtime (this relates to core hours where possible counting towards mentoring hours).

(3) APs should not work on an SRV unless they are SORT trained AND working on an SRV for this purpose.

(4) Technicians/AAP may only work on an SRV where this is part of their agreed rostered shifts.

(5) ECSWs may work together as a NET.

(6) Following their initial period of direct clinical support (usually 300 hours), an NQP can supervise at any stage, however, can only undertake formative mentoring of students once they have gained 12 month's experience **and** have completed the PEd 2 course.

(7) An NQP >300 hours could work with a non-clinical driver or ECSW <3 months as a NET, however this should be as a last resort and requires the agreement of the NQP (i.e., this cannot be enforced)

This section is intended to describe how staff working together identify the lead clinician providing care for their patient. This can be within a crew configuration, or on-scene where multiple resources are in attendance. Please refer to the Clinical Supervision Procedure for more information on supervision.

Lead Clinician	Consultant Paramedic	PP/CCP	Paramedic (inc Para' OTLs)	NQP	Technician/ Adv Tech/ AAP2	AP	AAP	ECSW
Consultant Paramedic								
PP/CCP								
Paramedic (inc Para' OTLs)								
NQP								
Technician/AAP2								
AP								
AAP								
ECSW								

	Does not lead this grade
	Can lead this grade
	Shared leadership (by agreement)

Appendix M (Medicines): Medicines Possession, Supply and Administration Authorised by Clinical Grade/Role

Key:

- **PGD:** Patient Group Direction (**n.b.** individual authority for the use of specific PGDs is included in the Professional Qualifications section in each PGD document. PGDs for patient use can only be used once authorised via the JRCALC+ PGD competency assessment function)
- **S17:** Schedule 17 of the Human Medicines Regulations 2012
- **S19:** Schedule 19 of the Human Medicines Regulations 2012*
- **ALS:** Persons who hold the advanced life support provider certificate issued by the Resuscitation Council (UK).
- **TA:** Trust approval and authority using JRCALC guidelines
- **Diluent:** Used only for diluting a medicine (water for injection)

***Please note**: some indications in JRCALC are not supported by Schedule 19 and so approval to use the medicine is specific to certain presentations, for example Adrenaline 1:1,000 cannot be used under Schedule 19 for Life Threatening Asthma.

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	**Presentation**	**Route(s)**	**Mechanism**	**Type of Use (administration, supply, both)**	**CFR / IECR**	**Emergency Care Support Worker**	**Associate Practitioner/AAP**	**Technician/ Advanced Technician**	**Paramedic (inc' NQP)**	**Paramedic Practitioner/Student PP****	**Critical Care Paramedic**
Activated Charcoal (P)	1 x bottle	Oral	TA	Administration					Yes	Yes	Yes
Adrenaline 1:10,000 (POM)	1mg/10ml	IV/IO	S17 / ALS	Administration					Yes	Yes	Yes
Adrenaline 1:1000 (POM) **FOR ANALPHYLAXIS ONLY**	500mcg[2]	IM	S19	Administration		AAI Only***	**IM Only**	**IM Only**	Yes	Yes	Yes
Alteplase	50mg/50ml	IV/IO	PGD	Administration							Yes
Amiodarone (pre-filled) (POM)	300mg	IV/IO	S17 / ALS	Administration					Yes	Yes	Yes

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	**Presentation**	**Route(s)**	**Mechanism**	**Type of Use (administration, supply, both)**	**CFR / IECR**	**Emergency Care Support Worker**	**Associate Practitioner/AAP**	**Technician/ Advanced Technician**	**Paramedic (inc' NQP)**	**Paramedic Practitioner/Student PP******	**Critical Care Paramedic**
Amoxicillin (POM)	500mg	PO	PGD	Supply						Yes	
Aspirin (P)	300mg	PO	TA	Administration	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Atropine 600mcg (POM)	600mcg	IV/IO	S19	Administration					Yes	Yes	Yes
Benzylpenicillin (POM)	600mg	IV/IO	S17	Administration					Yes	Yes	Yes
Calcium Chloride (POM)	10%/10ml	IV/IO	PGD	Administration							Yes
Chlorphenamine (POM)	10mg/1ml	IV/IO (IV preferred)	PGD	Administration					Yes	Yes	Yes
Cetirizine	10mg tablet	Oral	TA	Administration			Yes	Yes	Yes	Yes	Yes
Clarithromycin (POM)	125mg suspension	PO	PGD	Supply						Yes	
Clarithromycin (POM)	250mg tablet	PO	PGD	Supply						Yes	
Clopidogrel (POM)	75mg	PO	TA	Administration					Yes	Yes	Yes
Co-Amoxiclav (POM)	625mg	PO	PGD	Supply						Yes	
Co-Amoxiclav (POM)	1.2g	IV	PGD	Administration					Yes	Yes	Yes
Cyclizine										Yes	Yes
Dexamethasone	2mg	PO	PGD	Administration					Yes	Yes	Yes
Diazemuls IV (CD)	10mg/2ml	IV/IO	S17	Administration					Yes	Yes	Yes
Diazepam (CD)	2.5mg	PR	TA	Administration					Yes	Yes	Yes
Diazepam (CD)	5mg	PR	TA	Administration					Yes	Yes	Yes
Diazepam (CD)	10mg	PR	TA	Administration					Yes	Yes	Yes
Entonox (P)	NA	Inhaled	TA	Administration		Yes	Yes	Yes	Yes	Yes	Yes

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	**Presentation**	**Route(s)**	**Mechanism**	**Type of Use (administration, supply, both)**	**CFR / IECR**	**Emergency Care Support Worker**	**Associate Practitioner/AAP**	**Technician/ Advanced Technician**	**Paramedic (inc' NQP)**	**Paramedic Practitioner/Student PP******	**Critical Care Paramedic**
Flucloxacillin	250mg	PO	PGD	Supply						Yes	
Flumazenil (POM)	100 mcg	IV/IO	PGD	Administration							Yes
Furosemide (POM)	20mg/2ml	IV	S17	Administration					Yes	Yes	Yes
Glucagon (POM)	1mg	IM/SC	S19	Administration			Yes	Yes	Yes	Yes	Yes
Glucogel (P)	40%/23g	Buccal	TA	Administration		Yes	Yes	Yes	Yes	Yes	Yes
Glucose 10% (POM)	500ml	IV	S17	Administration					Yes	Yes	Yes
GTN (P)	400mcg	Sub lingual	TA	Administration			Yes	Yes	Yes	Yes	Yes
Heparin (POM)	5000 IU	IV	S17	Administration					Yes	Yes	Yes
Hydrocortisone (POM)	100mg	IV (preferred) IO/IM	S19	Administration			**IM Only**	**IM Only**	Yes	Yes	Yes
Hyoscine Butylbromide				Administration						Yes	Yes
Ibuprofen Suspension (P)	100mg/5ml	PO	PGD	Supply						Yes	
Ibuprofen Sachet (P)	100mg/5ml	PO	TA	Administration			Yes	Yes	Yes	Yes	Yes
Ibuprofen Tablet (P)	200mg	PO	PGD	Supply						Yes	
Ibuprofen Tablet (P)	200mg	PO	TA	Administration			Yes	Yes	Yes	Yes	Yes
Ipratropium Bromide (POM)	250mcg	Nebulised	TA	Administration			Yes	Yes	Yes	Yes	Yes
Ketamine (CD)	10mg/1ml	IV/IO	PGD	Administration							Yes
Ketamine (CD)	50mg/1ml	IV/IO	PGD	Administration							Yes
Levetiracetam (Keppra)											

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	**Presentation**	**Route(s)**	**Mechanism**	**Type of Use (administration, supply, both)**	**CFR / IECR**	**Emergency Care Support Worker**	**Associate Practitioner/AAP**	**Technician/ Advanced Technician**	**Paramedic (inc' NQP)**	**Paramedic Practitioner/Student PP****	**Critical Care Paramedic**
Lidocaine (Lignocaine) (POM)	1%	SC	PGD	Administration						Yes	
Magnesium Sulphate (POM)	2g or 4g (depending on PGD)	IV/IO	PGD	Administration							Yes
Magnesium Sulphate (POM)	150mg	Nebulised	PGD	Administration							Yes
Methoxyflurane (Penthrox) [4]	3 ml	Inhaled	PGD	Administration					Yes	Yes	Yes
Midazolam (CD)	5mg/5ml	IV/IO	PGD	Administration							Yes
Midazolam (High strength) (CD)	5mg/1ml	IV/IO	PGD	Administration							Yes
Misoprostol	200mg	PO	PGD	Administration					Yes	Yes	Yes
Morphine Sulphate (CD)	10mg/1ml	IV/IO/IM	S17 (PGD [1])	Administration					Yes	Yes	Yes
Naloxone Hydrochloride (POM)	400mcg/1ml	IV/IO/IM/IN	S19	Administration			**IM Only**	**IM Only**	Yes	Yes	Yes
Naproxen (POM)	250mg	PO	PGD	Supply						Yes	
Nitrofurantoin (POM)	50mg	PO	PGD	Supply						Yes	
Ondansetron (POM)	4mg	IV (IM/SC in EoLC)	S17	Administration					Yes	Yes	Yes
Oxygen (P)	NA	Inhaled	TA	Administration	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oral Rehydration Salts (GSL)	Sachet	PO	TA	Supply						Yes	
Paracetamol (POM)	10mg/1ml	IV	S17	Administration					Yes	Yes	Yes

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	**Presentation**	**Route(s)**	**Mechanism**	**Type of Use (administration, supply, both)**	**CFR / IECR**	**Emergency Care Support Worker**	**Associate Practitioner/AAP**	**Technician/ Advanced Technician**	**Paramedic (inc' NQP)**	**Paramedic Practitioner/Student PP****	**Critical Care Paramedic**
Paracetamol (P)	120mg/5ml suspension	PO	PGD	Administration					Yes	Yes	Yes
Paracetamol (P)	250mg/5ml suspension	PO	PGD	Supply						Yes	
Paracetamol (P)	250mg (Fastmelt/ oro-dispersible)	PO	PGD	Administration					Yes	Yes	Yes
Paracetamol (GSL)	500mg	PO	PGD	Supply						Yes	
Paracetamol (GSL)	500mg	PO	TA	Administration			Yes	Yes	Yes	Yes	Yes
Paracetamol (P)	120mg/5ml sachet (Calpol)	PO	TA	Administration			Yes	Yes	Yes	Yes	Yes
Penicillin V (POM)	250mg	PO	PGD	Supply						Yes	
Prednisolone (POM)	5mg	PO	PGD	Supply						Yes	
Prednisolone (POM)	1mg/1ml	PO	PGD	Administration					Yes	Yes	Yes
Prednisolone (POM)	1mg/1ml	PO	PGD	Supply						Yes	
Rocuronium (POM)	10mg/1ml	IV/IO	PGD	Administration							Yes
Salbutamol (POM)	2.5mg	Nebulised	TA	Administration	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sodium Chloride Ampoule (POM)	0.9% 10ml	IV/IO	S17	Administration					Yes	Yes	Yes
Sodium Chloride (P)	0.9% 100ml	IV/IO	S17	Administration							Yes
Sodium Chloride (P)	0.9% 500ml	IV/IO	S17	Administration					Yes	Yes	Yes
Sodium Chloride (hypertonic) (POM)	5% 500ml	IV/IO	PGD	Administration							Yes
Tenecteplase (POM)	10,000 units	IV	S17	Administration							Yes

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	**Presentation**	**Route(s)**	**Mechanism**	**Type of Use (administration, supply, both)**	**CFR / IECR**	**Emergency Care Support Worker**	**Associate Practitioner/AAP**	**Technician/ Advanced Technician**	**Paramedic (inc' NQP)**	**Paramedic Practitioner/Student PP****	**Critical Care Paramedic**
Ticagrelor (POM)	90mg	PO	PGD	Administration					Yes	Yes	Yes
Tranexamic Acid (POM)	500mg	IV	PGD	Administration					Yes	Yes	Yes
Trimethoprim (POM)	200mg	PO	PGD	Supply						Yes	
Water for Injection (P)	NA	IV/IO	Diluent	Administration					Yes	Yes	Yes

[1] - Only paramedics are covered by Schedule 17 of the Human Medicines Regulations. 2012. Other healthcare professionals may need to follow a PGD

[2] - AAI (Adrenaline Auto Injector). Authority to administer AAI's prescribed and dispensed to the patient named on the prescription when working with another ECSW (i.e., on NET vehicle). Dosage dependent on the type of AAI (EpiPen, Emerade, Jext etc). Patients should have two AAIs dispensed and both should be given by ECSWs with a 5-minute interval after initial AAI dose.

[3] - Student paramedic practitioners may use any PGDs where it is specifically stated in the PGD that they fulfil the criteria in the "Professional Qualification" section. Student paramedic practitioners can continue to use PGDs where the minimum qualification is paramedic.

[4] – Authorisation is only applicable once training and sign-off on the use of Penthrox has been completed.