South East Coast Ambulance Service NHS
NHS Foundation Trust

999 Incomplete Triage Calls Procedure

Contents

1 Scope

1.1. South East Coast Ambulance Service (the Trust) serves a diverse group of patients, and on occasions, are unable to complete a triage of their symptoms when they call for help.

1.2. Reasons for not being able to complete a triage of a patient's symptoms may include remote observers not with the patient and language barriers.

1.3. Patients whose symptoms are not fully triaged are vulnerable and risk deterioration during their wait for assistance.

1.4. This procedure lays out the management of these calls within the Emergency Operations Centre (EOC) during the call handling process and subsequent clinical review of these incidents.

1.5. The procedure does not cover the management of any third-party triaged calls that are handled in the 111 call centre.

1.6. It does not cover the management of any medical situation that may be identified once a response arrives, but covers all calls where the Trust has been unable to carry out an assessment of the patient's symptoms prior to organising a response.

1.7. The Trust is committed to providing high quality patient care.

1.8. This procedure is applicable to all staff in the Trust and sets out the scope of clinical practice to which clinicians must adhere.

2 Procedure

2.1. Call Handling for Remote Observers

2.1.1. Calls received from third party callers who are not with the patient will be triaged in accordance with the Emergency Operations Centre (EOC) call handling procedure, utilising NHS Pathways to reach a category 3 (C3) ambulance disposition in the absence of any declared or suspected life-threatening symptoms.

2.1.2. In line with the EOC Call Handling Procedure, the Emergency Medical Advisor (EMA) must attempt to call the patient directly, in order to complete a first- or second-party triage, regardless of the category of call.

2.1.3. If the EMA manages to contact the patient and no assistance is required, calls should be managed as per the Call Handling Procedure.

2.1.4. If an EMA manages to contact the patient and assistance is required, they must ensure they complete a first party triage utilising the NHS Pathways triage tool to reach an appropriate disposition for the patient.

2.1.5. If after two attempts to contact the patient, an EMA is unable to get hold of them, they must notify the next available Clinical Supervisor of the incident through the clinical in-line support phone function, ensuring full handover of any information already received as per the In-Line Support Procedure.

2.1.6. In the event of an EMA being unable to notify a clinician of the incident, they must notify the Operational In Line support of the call who will then be responsible for verbally handing over the incident number and area of concern, to a clinician within the room. This may in the first instance, be through using the Clinical In Line support line, or by directly approaching an available clinician.

3 Call Handling for patients with language barriers

3.1. Calls from non-English speaking patients will be handled in accordance with the EOC Call Handling Guide, and where required will be supported by the approved language translation service.

3.2. There will be times when the language translation provider has no interpreter available to support this triage. The EMA must attempt to explain that an interpreter is unavailable and gather as much information as possible and attempt to complete as much triage as is safely possible. If the EMA does not manage to triage the call due to the language barrier they must ensure they notify the next available clinical supervisor of the call through the in-line support function, to advise the call has not been fully triaged.

3.3. In the event of an EMA being unable to notify a clinician of the incident they must notify the Operational In Line support of the call who will then be responsible for notifying a clinician within the room of the incident.

3.4. Clinical Review and call back

3.4.1. The Clinical Supervisor notified of these incomplete triage incidents, will complete a clinical review of the call to determine the level of risk to the patient, in line with the EOC Clinical Review Guidelines - clinical bulletin, and utilising the guidance review points in Appendix A. These review points apply to clinicians clinically reviewing calls, and not to any other groups of staff.

3.4.2. This review will include reviewing all information provided by callers, review of any centrally held clinical records and a review of previous call history to the address.

3.4.3. The Clinical Supervisor will make a dynamic risk assessment of the information within the incident and any relevant medical information, to decide whether the call should be upgraded straight away to a category 2 response without attempting to triage with the patient directly.

3.4.4. For any remote observer calls, in the absence of any concerning features, the EOC clinician will make attempts to contact the patient. A best practice approach needs to be adopted for the management of these calls, and up to 3 attempts to contact the patient will be made over a 15-minute period.

3.4.5. For all language barrier calls, the EOC clinician will make a dynamic assessment of any available information, to determine the need to attempt a call back to scene.

3.5. **Call Upgrading and Prioritisation**

3.5.1. Following a clinical review of the call, which may include attempts to contact the patient and complete a triage, the clinician will make the decision to either leave the incident as a category 3 response, prioritise (remaining as a C3) within the Operational Dispatch Area or upgrade the call to ensure a timely response to the patient.

3.5.2. Upgrading of the call to a C2 ambulance disposition can occur at any time before completion of any call back attempts and will be completed if there are any areas of concern for the patient's welfare.

3.5.3. Calls where the decision has been made to upgrade the response to a higher priority, or we are unable to get hold of the patient, should be manually upgraded to a higher response in line with the Clinical Supervisor Local Operating Procedure. Appropriate documentation must be made within the incident providing the rationale for the upgrade.

3.5.4. Incidents where the clinician manages to get hold of the patient, must be triaged using a Trust approved Clinical Decision Support System (CDSS).

3.5.5. Any upgraded incidents will be prioritised in line with the clinical needs of the other outstanding incidents within that Operational Dispatch Area (ODA), however a low threshold should be held for prioritising these types of calls above any other work due to the patient vulnerability and current unknown reason for the call.

3.5.6. Any incidents that have been clinically reviewed and the clinician feels the call does not need to be upgraded or prioritised, must have clear notes added to the CAD (Computer Aided Dispatch) to explain the rationale for this decision.

4 Definitions

4.1. **CAD –** Computer Aided Dispatch System, a system utilised within the Trust to hold information regarding patients calling for assistance, and dispatching ambulance resources to.

4.2. **Clinical Review –** a systematic review of the incident to assess the risk level of the patient, can include age, time of call, description of call and any relevant clinical information relating to the patient.

4.3. **CDSS –** Clinical Decision Support System – a system used to support telephone triage of patients.

4.4. **EMA –** Emergency Medical Advisor, an employee of the Trust, trained in the use of NHS Pathways, responsible for answering incoming calls from the public and other health care professionals.

4.5. **ODA –** Operational Dispatch area, a geographical area of the Trust that will be attended to by a dedicated Resource Dispatcher and will have available resources scheduled to work within the area.

Appendix A – Clinical Review Guidance

Points to Consider	Rationale
Patient's age	Children and older adults are more vulnerable
Problem nature	The patient's presenting complaint allows a clinician to identify potential lower acuity problems that may benefit from further clinical assessment or, conversely, higher acuity problems that may be indicative of a serious condition.
Origin of call (e.g. first/second/third party, partner agency, HCP)	Consider the validity of the triage assessment during the initial call. For example, a third-party triage is less reliable and safe than that of a first or second party. If the call has been made by a Health Care Professional it may contain pertinent clinical information that will aid decision making.
If the patient is alone	Patients who are alone may represent a red flag. It means that if they need to escalate changes/concerns themselves it may be difficult for them to do so. It also means that there is no one observing how they are and so any deterioration may not be picked up
Call/Crew notes	Call/Crew notes provide further information and more specific detail that may assist with the management of the call.
CDSS Triage summary	NHS Pathways (NHSP) is the Trust's approved CDSS used for primary 999 call taking within the EOC. Consider pathway used, answers to key questions and associated notes to assess risk.
At-risk markers (e.g. blue clinical markers)	This means specific information about the patient has been pre-obtained, validated and stored on the CAD. It should be used, where applicable, in call taking and onward planning of care to meet the patients' needs safely and managing risk.
Electronic patient records or care plans (e.g. IBIS, CPMS, Share My Care or Summary Care Record)	Patient records (such as Summary Care Record, CPMS and Share My Care) provide a baseline of historic clinical information that can support clinical decision making. Care plans (such as IBIS and SCR-with Additional Information) are made for specific 'known patients' who are particularly complex or vulnerable. Care plans should be accessed and considered as they contain instructions for anticipatory care and treatment.

Location History	It is important to consider any location history on CAD for previous calls to the same patient. The history may provide useful information to help in assessment and risk management. Pay particular note to repeat callers (3 calls in a 96-hour period for the same complaint) as this is a potential red flag for an unrecognised serious issue.
Disposition	Consider the call disposition and expected timeframe for attendance, in relation to the triage assessment and information given. Patients who are within the initial disposition timeframe carry less risk, however consideration should be made for early escalation if delays are expected. Patients outside the initial disposition timeframe carry higher levels of risk.
Level of Surge	The number of outstanding calls, both Trust-wide and within the individual ODA, should be considered to ascertain expected delays. Consideration should be made as to early escalation vs. impact on other outstanding calls, within the management of risk.

5 Responsibilities

5.1. The **Chief Executive Officer** is accountable for the overall effectiveness of this procedure.

5.2. The **Medical Director** has delegated responsibility for matters relating to patient safety and clinical effectiveness.

5.3. The **Director of Nursing** has responsibility for matters relating to quality, regulatory compliance and risk management.

5.4. The **Director of Operations** has responsibility for the operational compliance of this procedure.

5.5. The **Associate Director of Operations** has responsibility for the full implementation within EOC of this procedure, including the monitoring, audit and review once implemented.

5.6. The **Senior Clinical Operations Manager** has responsibility for ensuring the implementation of this procedure across the Trust's EOCs. They are also responsible for the monitoring, audit and review of this procedure once implemented.

5.7. The **Operations Managers Clinical** have responsibility for ensuring the implementation of this procedure across the trusts EOCs. They are also responsible for the monitoring, audit and review of this procedure once implemented.

5.8. The **Clinical Safety Navigators** have responsibility for ensuring the implementation of this procedure across the trusts EOCs.

5.9. The **Incident Reporting Group** is responsible for the ongoing effectiveness of this procedure.

5.10. **All employees** are responsible for adhering to this procedure.

6 Audit and Review (evaluating effectiveness)

6.1. This procedure once implemented, will be subjected to a one day, one week and one-month review of its effectiveness to ensure these process changes provide a positive impact to patient care, without negatively impacting on the service or its reputation.

6.2. All procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new procedure is approved and disseminated.

6.3. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

6.4. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the procedure is not working effectively.

6.5. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies**.**

7 Associated Trust Documentation

7.1. Calling Back of Careline Patients Bulletin

7.2. EOC Call Handling Procedure

7.3. Clinical Call Prioritisation – Operational Bulletin

7.4. EOC Clinical Review Guidelines – Clinical Bulletin

7.5. In-Line Support Procedure

8 Equality Analysis

8.1. 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.

8.2. 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.