South East Coast Ambulance Service NHS
NHS Foundation Trust

Clinical Advice (Call Back) Procedure

Contents

1 Scope

1.1. Shared clinical decision-making is the most effective way to reduce clinical risk. It is an essential tool when a clinician is deciding on the appropriate outcome for their patient, supporting care, avoiding unnecessary admissions and promoting appropriate referrals.

1.2. This procedure describes the process for Paramedic Practitioners (PPs) and Clinical supervisors (CS) to generate a 'call-back' on the Computer Aided Dispatch (CAD) system in the Emergency Operations Centre (EOC) and Paramedic Practitioners / Operational Team Leaders to remotely manage those call backs.

1.3. This procedure does not relate to 'clinical call-backs' generated through NHS Pathways telephone triage.

1.4. This procedure details the process for when a clinician on scene with a patient requests a call-back for collaborative clinical decision-making.

1.5. This procedure will ensure that on-scene clinicians receive a call-back in a timely manner by utilising operational clinicians to support the demands for call-backs.

1.6. Clinical call-backs may be for collaborative clinical decision making, supported discharge or assistance with referral pathways. This procedure should be used in conjunction with the Scope of Practice Policy and the Referral, Discharge and Conveyance Policy.

2 Procedure

Please see Appendix A for Standard Operating Procedure flowchart

2.1. **On-scene clinician**

2.1.1. Contacts Resource Dispatcher (RD) in EOC via airwave radio and asks for a clinician call-back.

2.1.1.1. Call back options may include specialist advice as well as shared clinical decision making.

2.1.2. Gives a brief description of the nature of call back (e.g. possible PP referral, chest infection, Toxbase enquiry, collaborative decision-making).

2.1.3. If the call back is time critical please ensure an urgent call back is requested.

2.1.4. Ensures RD is given an appropriate phone number for the call back.

2.2. **EOC Resource Dispatcher (RD) – creating a crew call-back request**

2.2.1. Locates and opens the incident the vehicle is assigned to on CAD.

2.2.2. Clicks 'ECAL' (Emergency Call Advice Line) request, selects the required response level advised by crew (urgent or routine) and which EOC clinician they would like to speak to (clinical or PP). RD then clicks 'save ECAL'.

2.2.3. Checks that the call-back has appeared in the clinical call-back queue.

2.2.4. Ensures contact phone number for the on scene clinician is documented in the CAD incident.

2.3. **EOC Clinician**

2.3.1. EOC Clinicians should be the first point-of-call to manage the ECAL workload.

2.3.2. Opens the next ECAL request, in order of clinical urgency.

2.3.3. Reviews the CAD notes to verify they are the most appropriate EOC clinician to undertake the call-back. If they feel that another EOC clinician would be more appropriate to deal with that case, enters Call Notes to explain rationale and highlights the incident to the most appropriate clinician.

2.3.4. Prior to calling the on-scene clinician, enters their PP call sign (e.g. PD01) or Clinical Supervisor call sign (e.g. CA01) into the Call Notes to indicate to other EOC clinicians and RDs that they are undertaking the call-back. If calls are directed to operational clinicians, this must be documented in the CAD.

2.3.5. During the call-back, clinical notes should be entered into the CAD to support and reflect the peer-to-peer discussion. Clinical notes can include, but not exclusively; PC, HPC, ROS, OE, Obs, PMH, Meds, Allergies, SHx, Plan and appropriate outcome. It should be ensured that the rationale for decisions is documented.

2.3.6. If the EOC Clinician utilises FaceTime the phone line must not be disconnected, to ensure that conversations are still recorded.

2.3.7. At the end of the call-back the clinician ticks the 'ECAL completed' box followed by 'save ECAL'. This will remove the incident from the clinical call-back stack on the CAD.

2.4. **Clinical Safety Navigator (CSN)**

2.4.1. The CSN in EOC can request assistance from operational Paramedic Practitioners (PPs) in the first instance or Operational Team Leaders (OTLs) in extreme circumstances to support clinical call-backs at times when there is increasing demand on EOC Clinicians, which may affect crews receiving call-backs within a reasonable timeframe.

2.4.2. The decision to utilise operational PPs and/or OTLs should be made by the duty CSN only, as they have oversight and responsibility for regional

EOC clinical activity/operations. If this decision is made, the CSN will liaise with relevant Dispatch Team Leaders (DTLs) and Resource Dispatchers (RDs) to inform them that their operational PPs/OTLs are to be used for call-backs. The CSN will also inform the CS/PP team in EOC that operational PPs/OTLs are being used within a specific ODA(s). The CSN will review regularly and inform DTLs/RDs/CSs when call-back responsibility is returning to the EOC Clinicians.

2.4.3. In areas where there are remote PP Hubs, the CSN will be responsible for liaising with the hub PP and organising a point of contact within the EOC who will be responsible for forwarding the details of call-backs, which require completion.

2.5. **Operational/Hub Paramedic Practitioner (PP) or Operational Team Leader (OTL)**

2.5.1. Operational/Hub PP/OTL to call the on-scene clinician who requested the call-back, on a Trust phone via the OPEX telephone recording system. **See Appendix B**

2.5.2. Provides collaborative clinical decision making to support the on-scene clinician in the safe referral/discharge/conveyance of the patient, as per the Scope of Practice Policy.

2.5.3. Uses CAD Online to add clinical notes into the incident, within the 'Call Notes' section. If CAD Online is not available, the clinical notes should be documented on a paper continuation form, using the correct incident/daily ID number and the PP/OTL call sign.

2.5.4. EOC (DTL/RD/CSN) should be updated by the operational/hub PP or OTL once they have completed the call-back.

2.5.5. If a Category 1 call is received whilst the PP/OTL is undertaking a call-back, and they are the closest resource, they must stand down from the clinical advice call, informing their Resource Dispatcher whether a further clinical call-back is required or the incident is complete.

2.5.6. If an operational/hub PP agrees with the on-scene clinician to generate a PP Referral the PP must contact their Resource Dispatcher and request the incident is converted into to a PP Referral, within a 2 hour timeframe (4 hours in exceptional circumstances i.e. where there is exceptionally high demand and the outcome for the patient is not affected). In times of Surge Management Plan (SMP) 3 and above, PP Referrals will not be routinely booked, however this can be discussed with the duty Clinical Safety Navigator.

2.6. **EOC Resource Dispatcher (RD) – allocating an operational/hub PP or OTL**

2.6.1. When the duty Clinical Safety Navigator requests an operational PP/OTL to be assigned to a call-back, the closest clinician to the incident should be assigned.

2.6.2. If a Category 1 call is received whilst the PP/OTL is undertaking a call-back and they are the closest resource, the PP/OTL should be contacted via airwave radio asking them to attend the Category 1 call. The RD should find out if the clinical call-back has been completed or whether it needs to go back into the ECAL queue for re-allocation.

2.7. If an operational/hub PP, following a clinical call-back, would like to generate a PP Referral, and there is suitable availability of PPs, the RD must downgrade the incident on CAD to a PP Referral within a 2 hour timeframe. In specific cases it may be appropriate to extend the timeframe with agreement from the Safety Navigator. This timeframe can be extended to up to 4 hours i.e. when no PP is currently on shift but one is due on shift within the 4 hour window.

2.8. **Surge Management Plan (SMP)**

2.8.1. There is no specific timeframe for call-back on these clinical advice calls therefore this does not change when SMP is in place.

3 Definitions

3.1. Datix is the Trust's incident management system.

4 Responsibilities

4.1. The **Chief Executive Officer** is accountable for patient safety.

4.2. The **Medical Director** has responsibility for clinical practice in the Trust.

4.3. The **Consultant Paramedics** are responsible for managing and implementing the procedure, and for the monitoring and auditing process through the Professional Practice and Clinical Pathways Group.

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

5 Audit and Review (evaluating effectiveness)

5.1. Incidents generating Clinical call-backs will be monitored using data collection. This will be collated into a quarterly report by the **Quality Assurance Officer** and presented to the Professional Practice Working Group.

5.2. Calls will be randomly audited using the clinical call-back audit tool (appendix C) The audit results will be fed back to the relevant clinicians.

5.3. Any Incident Requiring Investigation should be reported via the Datix reporting system.

5.4. This procedure's effectiveness will be audited by the Clinical EOC group.

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

5.6. 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).

5.7. 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 policy is not working effectively.

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

6 Associated Trust Documentation

6.1. Mobile Device Policy.

6.2. Information Governance Policy

6.3. E-mail and use of the Internet Policy

6.4. Data Protection Policy

6.5. Scope of Practice and Clinical Standards Policy

6.6. Health Records Management Policy

6.7. Referral, Discharge and Conveyance Policy

6.8. Referrals Procedure

6.9. Discharge Procedure

6.10. Urgent Care Handbook

6.11. Clinical Support Plan C219- EOC Clinical support

6.12. Surge Management Plan

6.13. Opex User Guide

6.14. Crew Call Back Flow proposal

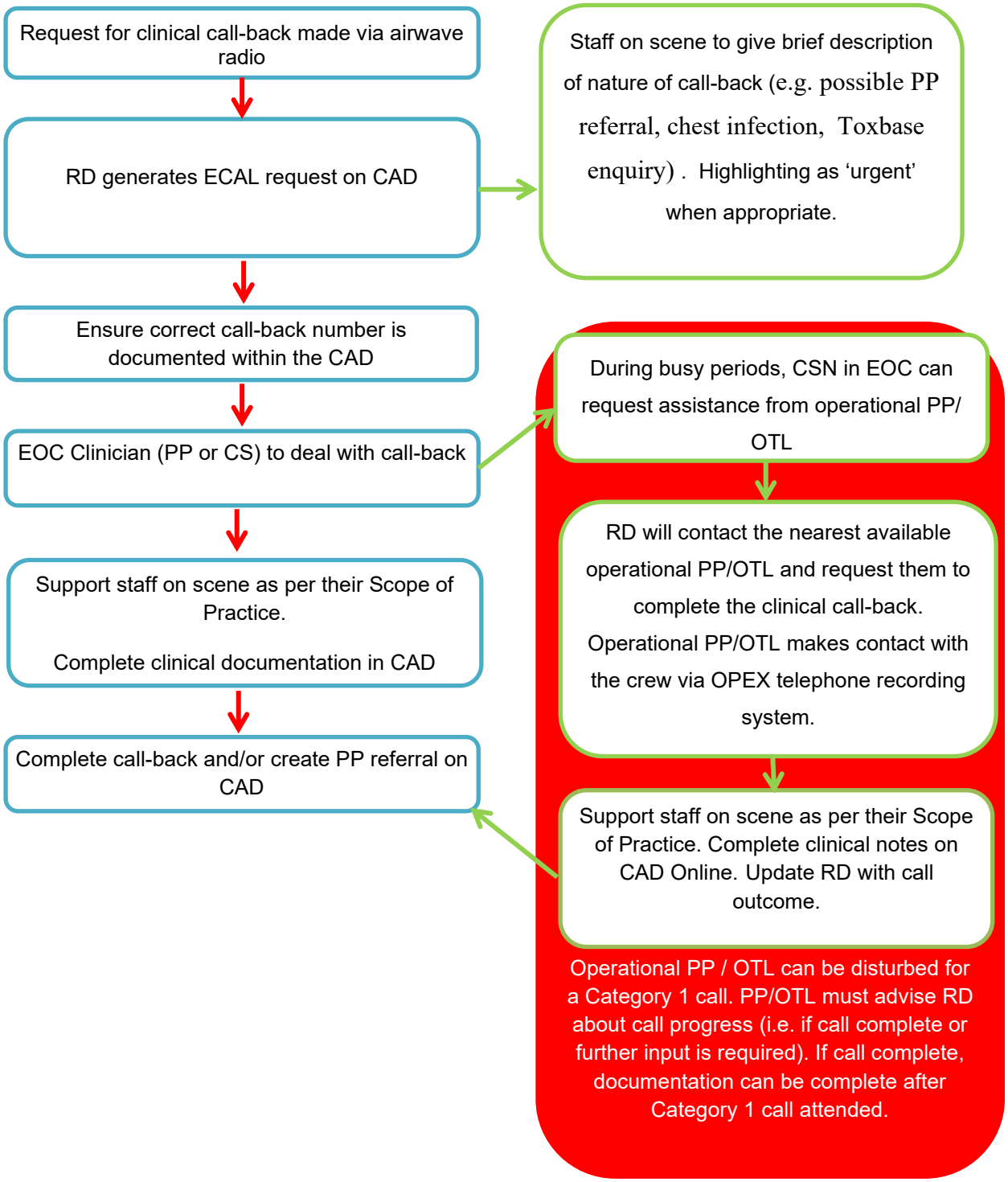
7 Equality Analysis

7.1. 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.

7.2. 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.

Appendix A

Clinical Advice Queue procedure flow chart

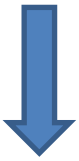


Appendix B

OPEX user guide

Operation/Hub PP or OTL to call the following number:
01324 468175
You will then hear a dial tone

Enter the telephone number of the on scene clinician, followed by this pin number:
3618



The call will connect to the number dialled, the conversation will then be recorded through this OPEX system

Appendix C

South East Coast Ambulance Service NHS
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Crew Call Back Audit

Clinician Name		Dave Jones	FURTHER INFO	
Auditor Name				
Case Reference			Call Date	
Call Reference			SELECT ↓	Notes
Information Gathering	1	Clear Introduction. Introduces themselves in line with NHS ethos of "Hello my name is..." This includes introduction from the refering and the receiving clinicians		
	2	Confirmed patient details and appropriate demographics		
	3	Clearly records reason for call within Consultation screen (have reviewed pc/hpc and o/e here as forms basis of advice for pt outcome questioning here		
	4	Discussed Previous Medical History		
	5	Discussed Current Treatements and Medications & Allergies		
	6	Discussed Crew / On-Scene actions and Treatments. Ensured recommendations were within the SOP of the attending clinician		
	7	Review of advice relating to medication outside of crews scope of practice and ensured they fully understood advice		
Clinical Decision Making	8	Does the Agent utilise additional support for clinical decision making where appropriate (eg medicines complete, BNF etc)		
	9	Clincial Decision to idenify appropriate care utilising patient mangement strategies ie falls referral/diabetic referal informing gp if appropriate		
	10	Did the PP follow a systematic approach? Was there a logical progression throughout the call back? Appropriate follow up questions?		
Engagement with Crew	11	Telephone conversation flowed easily		
	12	The crew was listened to with dignity and respect		
	13	Questions answered appropriately - Did the agent answer questions using language that the on scene clinican understood		
Use of System, policies and procedures to support and meet patient needs	14	Call back completed in a timely manner		
	15	Call Completed appropriatley through system use (ECAL completed or delayed conveyance/pp referral with accurate notes added into CAD Patient Record as appropriate)		
	16	Local policies/guidance, Clinical call back and conveyance/referral, safeguarding procedures followed		
Supported appropriate patient outcome	17	Outcome agreed/negotiated with Patient / Carer / Crew		
	18	Patient/carer happy with outcome		
	19	Consideration to alternate pathways considered here and reasons documented if not appropriate		
		Overall Result		Save For Feedback
TOTAL		**0%**		**Fail**

To pass the call must achieve a score of 86 or above

Key:

Full achievement: this means the indicator was demonstrated to a good/excellent standard or that the indicator did not apply to the circumstances of the call.

Partial achievement: this means the indicator was adequately demonstrated and that any issues identified in relation to this indicator did not affect the overall safety and/or quality of the call.

Not achieved: this means the indicator was not adequately demonstrated and the issues identified detracted from the overall safety and/or quality of the call.