South East Coast Ambulance Service NHS
NHS Foundation Trust

Scope of Practice and Clinical Standards Policy

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 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, 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 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. Where clinical roles emerge which include fully independent practice, these roles should be included in this document.

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. Helicopter Emergency Medical Services (HEMS) charities. This includes geographically coterminous HEMS units and those which attend in the Trust region as part of mutual aid arrangements within the UK HEMS sector (for example, London HEMS attending incidents in SECAmb area).

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 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 and ongoing registration.

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.

3.5.1. When working as a care team, most tasks relating to medicines possession and administration cannot be delegated by paramedics using PGD and/or exemptions. Please refer to Medicines Policies and Procedures. Other delegated tasks must fall within either relevant scope for other grades or be proportionate in context to the delivery of care.

3.5.2. With regards to student paramedics….

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 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.

3.9.2. 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. **Clinical Supervision**

3.11.1. Clinical supervision is an intrinsic aspect of professional practice and staff must engage with supervisory activities.

3.11.2. Please refer to the latest version of the Clinical Supervision Procedure for guidance.

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

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

3.12.1.1. 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.

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

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

3.12.2. 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.

3.12.3. 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.

3.13. **Referrals to Professional Regulators**

3.13.1. 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.

3.13.2. 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.

3.13.3. 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.

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

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

3.14.1. 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.

3.14.2. 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.

3.15. **Amending the scope of practice**

3.15.1. 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.

3.15.2. 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.

3.16. **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).

3.17. 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).

3.18. **All Trust staff must:**

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

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

3.18.3. Maintain confidentiality.

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

3.18.5. Exercise a duty of care.

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

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

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

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

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

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

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

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

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

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

3.19.5. 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.

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

3.20.1. Be able to gather appropriate information.

3.20.2. Be able to use appropriate assessment techniques.

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

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

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

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

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

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

3.22.2. 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.

3.22.3. 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).

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

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

3.23.1. 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).

3.23.2. 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.

3.23.3. 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.

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

3.23.5. 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).

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

3.23.7. 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.

3.23.8. 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.

3.23.8.1. 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 References

9.1. Joint Royal Colleges Ambulance Liaison Committee (JRCALC)

9.2. Health Care and Professions Council standards documents.

9.3. Nursing and Midwifery Council code and standards documents.

9.4. General Medical Council: Standards Guidance for Doctors

9.5. College of Paramedics Career Framework (2017)

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

10 Equality Analysis

10.1. 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.

10.2. 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: 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 / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
Types of calls attended	All Calls Restricted list	A R		R	R	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	U	U	U	U	U	U
Medicines administration			Policy										
	Just in Case		Ref 3										
	Administer Prescribed &		Ref 4										

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	dispensed medicines												
	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 *Only with critical caret background									A	A*	A*
	Endotracheal Intubation (paeds)										A	*	*
	Laryngoscopy (and use of Magill forceps) for FBOA.												
	Needle Cricothyroidotomy												*

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	Surgical Airway (Front of Neck Access – FONA)											*	*
	BVM (Adult) Lone and 2 persons												
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		*	*

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	Tibial intraosseous												
	Femoral intraosseous	A - Requires evidence of training						A	A	A		*	*
Routes Of Medicines Administration			Policy										
	Oral												
	Sublingual												
	Buccal												
	Intranasal		Ref 7 (non-parenteral POMs)										
	Inhaled												
	Rectal												
	Sub-cutaneous	R = Glucagon only					R						
	Intramuscular												
	Intravenous												
	Intraosseous												
	Preparation of parenteral medicines					Exc' CDs	Exc' CDs						

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
Referral and Discharge Rights													
Referral rights	Primary Care	Full (F) Supported (S) None (N)	Ref 8 - AAP/Tech & NQP	N	N	N	S	F	F	F	F	F	F
	Secondary Care	Full (F) Supported (S) None (N)		N	N	N	S	S	F	F	F	F	F
	Tertiary Care	Full (F) Supported (S) None (N)		N	N	N	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	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)		N	N	F	F	F	F	F	F	F	F

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
		None (N)											
	Tertiary Care	Full (F) Supported (S) None (N)		N	N	S	S	S	S	F	F	F	F
	Delayed Conveyance	R = When on SRV only		N	N	N	R		F	F	F	F	F
Diagnostics/Observations													
	Automated Blood Pressure												
	Manual Blood Pressure												
	Pulse Oximetry												
	Capnography												
	Blood glucose		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						

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	Peak flow		Ref 12										
Basic Chest Examination	Inspection, Palpation and Auscultation to guide treatment												
Full Chest Examination (in line with physical assessment module completion)	Inspection												
	Percussion												
	Palpation												
	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						
Neurological assessment	FAST. Gross sensation, sight, gait abnormalities		Ref 14										
	Cranial Nerve exam												

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	Dizziness assessment		Ref 14				R						
Thermometry	Tympanic												
	Infrared												
	Oesophageal												
Otoscope												*	
Ophthalmoscope												*	
Ultrasound												*	*
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												
	Manual Defibrillation (Adult)		Ref 15										
	Manual Defibrillation (Paeds)		Ref 15										

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	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)	**If SWAMP trained							**				
	Closure (glue)	R = GATSO							R			*	
	Closure (sutures)	If trained (T)										*	
	Dressing	Requires advice (R) Basic 1st Aid only (B)		R	B	R							
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/					S						

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
		supervision (S)											
	Spinal 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										
	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													

Practice Area/ Skill	Variables/ Sub heading	Key	Link to further information	CFR / ER	IECR	Emergency Care Support Worker	Technician/ Associate Ambulance Practitioner	Newly Qualified Paramedic	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic	Consultant Paramedic*	Doctor*
	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. Only CFRs trained to operate as Emergency Responders and who have completed an approved emergency driving course can respond under emergency conditions.
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. <u>Intimate examinations</u> 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. <u>Intimate Interventions</u> 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 <u>Training and education</u>

Reference Number from Appendix A	Title	Definition
		Authority to undertake intimate examination and intervention is only applied following the trust-approved training programme overseen by the Consultant Midwife.
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)

Reference Number from Appendix A	Title	Definition
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.
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,

Reference Number from Appendix A	Title	Definition
		• 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)'
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. Examinations for that grade includes only FAST testing and assessment of gross PNS function.
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 encouraged 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.

Reference Number from Appendix A	Title	Definition
	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.

		Consultant Paramedic	APPUEC /CCP	Paramedic (inc Para' OTLs)	NQP	AAP/Technician	ECSW
Lead Clinician	Consultant Paramedic						
	APPUEC/CCP						
	Paramedic (inc Para' OTLs)						
	NQP						
	AAP/Technician						
	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 / ER / IECR**	**Emergency Care Support Worker**	**AAP/Technician**	**Paramedic**	**Advanced Paramedic Practitioner (UEC)**	**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) (**Tech/AAP: FOR ANAPHYLAXIS ONLY)**	500mcg[2]	IM	S17 (paramedics only) & S19	Administration	AAI Only***	AAI Only***	**IM Only**	Yes	Yes	Yes
Alteplase	50mg/50ml	IV/IO	PGD	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 / ER / IECR**	**Emergency Care Support Worker**	**AAP/Technician**	**Paramedic**	**Advanced Paramedic Practitioner (UEC)**	**Critical Care Paramedic**
Amiodarone (pre-filled) (POM)	300mg	IV/IO	S17 / ALS	Administration				Yes	Yes	Yes
Amoxicillin (POM)	500mg	PO	PGD	Supply					Yes	
Aspirin (P)	300mg	PO	TA	Administration	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) **FOLLOWING ANAPHYLAXIS ONLY**[5]	10mg/1ml	IV/IM	Sch 19	Administration			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

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	Presentation	Route(s)	Mechanism	Type of Use (administration, supply, both)	CFR / ER / IECR	Emergency Care Support Worker	AAP/Technician	Paramedic	Advanced Paramedic Practitioner (UEC)	Critical Care Paramedic
Diazepam (CD)	10mg	PR	TA	Administration				Yes	Yes	Yes
Entonox (P)	NA	Inhaled	TA	Administration		Yes	Yes	Yes	Yes	Yes
Flucloxacillin	250mg	PO	PGD	Supply					Yes	
Flumazenil (POM)	100 mcg	IV/IO	PGD	Administration						Yes
Fosfomycin	3g	PO	PGD	Supply					Yes	
Furosemide (POM)	20mg/2ml	IV	S17	Administration				Yes	Yes	Yes
Glucagon (POM)	1mg	IM/SC	S19	Administration			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
Heparin (POM)	5000 IU	IV	S17	Administration				Yes	Yes	Yes
Hydrocortisone (POM)	100mg	IV (preferred) IO/IM	S19	Administration			**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
Ibuprofen Tablet (P)	200mg	PO	PGD	Supply					Yes	
Ibuprofen Tablet (P)	200mg	PO	TA	Administration			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 / ER / IECR**	**Emergency Care Support Worker**	**AAP/Technician**	**Paramedic**	**Advanced Paramedic Practitioner (UEC)**	**Critical Care Paramedic**
Ipratropium Bromide (POM)	250mcg	Nebulised	TA	Administration			Yes	Yes	Yes	Yes
Ketamine (CD)	10mg/1ml	IV/IO	PGD	Administration						Yes
Ketamine (CD)	50mg/1ml	IV/IO	PGD	Administration						Yes
Levetiracetam (Keppra)										Yes
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	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**	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

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	**Presentation**	**Route(s)**	**Mechanism**	**Type of Use (administration, supply, both)**	**CFR / ER / IECR**	**Emergency Care Support Worker**	**AAP/Technician**	**Paramedic**	**Advanced Paramedic Practitioner (UEC)**	**Critical Care Paramedic**
Oxygen (P)	NA	Inhaled	TA	Administration	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
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	TA	Administration			Yes	Yes	Yes	Yes
Paracetamol (P)	250mg (Fastmelt/ oro-dispersible)	PO	PGD	Supply					Yes	
Paracetamol (GSL)	500mg	PO	PGD	Supply					Yes	
Paracetamol (GSL)	500mg	PO	TA	Administration			Yes	Yes	Yes	Yes
Paracetamol (P)	120mg/5ml sachet (Calpol)	PO	TA	Administration			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

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	**Presentation**	**Route(s)**	**Mechanism**	**Type of Use (administration, supply, both)**	**CFR / ER / IECR**	**Emergency Care Support Worker**	**AAP/Technician**	**Paramedic**	**Advanced Paramedic Practitioner (UEC)**	**Critical Care Paramedic**
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
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.

[5] – Not for administration in isolation. Part of post-therapy care of anaphylaxis only. This should be paramedic-led under normal circumstances.