Emergency Breakaway Procedure

Contents

1 Scope

1.1. This document describes the processes and safeguards associated with attending to another 999 call while engaged on a current call (Emergency Breakaway).

1.2. Ambulance services dispatch upon incidents in order of priority and time of call in line with Ambulance Response Programme (ARP) standards.

1.3. Categories of emergency calls vary between C1 (life threatening emergency) to C4 (non-emergency).

1.4. Specialist resources within SECAmb (the Trust) are comprised of Commanders, Critical Care Paramedics (CCPs), Advanced Paramedic Practitioners (AdvPPs), Hazardous Area Response Team (HART) and Specialist Operations Response Team (SORT). Each has a specific scope of practice which is over and above that of frontline clinicians. Dispatch of these resources, is targeted to ensure that they attend the most appropriate incidents for their commissioned skill set.

1.5. Specialists may be tasked to incidents which are subsequently found to not require specialist interventions. Whilst on scene, it may become necessary for that specialist resource to become available for further specialist taskings.

1.6. The Trust has a duty to ensure the availability of specialist resources is optimised. This includes ensuring they can attend the most appropriate incidents, as well as ensuring regional and national availability.

1.7. This procedure outlines the circumstances, and procedure, in which a specialist or non-specialist resource can safely leave a patient to attend another incident.

1.8. Non-specialist resources such as Single Response Vehicles (SRVs) or Double Crewed Ambulances (DCAs) should only complete an emergency breakaway for confirmed cardiac arrests where arrival on scene will be before any other resource.

1.9. This procedure outlines the approach where a resource may be re-assigned while committed to an incident or allow incidents to be assigned to the same call-sign concurrently.

1.10. This document will justify the ethical viewpoint, and to guide staff to make an informed decision as to whether an emergency breakaway is appropriate.

1.11. EOC dispatch actions will be required when a clinician or specialist resource utilises this procedure.

1.12. This procedure will be used in conjunction with the 'Dispatch Standard Operating Procedure' and 'Referral Discharge and Conveyance Policy'.

2 Procedure

2.1. An emergency breakaway occurs when a crew are on scene and are required to attend a confirmed cardiac arrest or specialist deployment.

2.2. Both situations will have the same clinical safety and ethical considerations applied.

2.3. Where there is more than one resource on scene, this policy will not be applied as the patient will be in the care of another clinician. For example, when an SRV and DCA are on scene with a patient, they will remain safely in the care of the other clinician.

2.3.1. Emergency breakaway should only be considered where a specialist resource is required at an incident or for non-specialist resources where there is a confirmed cardiac arrest.

2.3.2. Before clinicians action an emergency breakaway, the current patient should be provided with a sufficient rationale for this decision and what will happen next, for example the same crew will return later or another Health Care Professional will be in touch following a referral.

2.3.3. Considerations for an emergency breakaway should be based on the presentation of the current patient:

- No harm should come to the current patient.
- Future harm should be minimised.
- Patient dignity should be maintained.
- Patients should be respected, and their wishes should be considered in the decision making.

- The risk to the current patient should be minimised by providing worsening care advice.

2.3.4. The clinician on scene has ultimate responsibility for deciding to implement an emergency breakaway.

2.4. **Emergency Breakaway while on scene**

2.4.1. This aspect of the emergency breakaway process is for Trust resources that are on scene and have made patient contact.

2.4.2. There are occasions where Trust resources are on scene of an incident and they are nearby to a confirmed cardiac arrest following a general broadcast.

2.4.3. Clinicians on a DCA are not permitted to split and must both remain as a crew on their vehicle.

2.4.4. Emergency breakaway should only be considered where the clinical safety of the current patient is unlikely to be compromised.

2.4.5. Clinicians offering to breakaway must not clear themselves from the original incident on the Mobile Data Terminal (MDT) within Trust vehicles as this will cancel the incident and will no longer be viewable by the dispatch teams. The Resource Dispatcher or specialist resource desk will perform this function.

2.4.6. **EOC Actions**

2.4.7. Specialist resources will be notified of incidents requiring attendance by a Resource Dispatcher (RD), Dispatch Team Leader (DTL), or specialist resourcing desk within EOC.

2.4.8. Notification of cardiac arrests will be sent via a general broadcast.

2.4.9. Resources will volunteer to attend if appropriate.

2.4.10. Specialist Resources may require more detailed information so an informed decision can be made to breakaway.

2.4.11. It should never be assumed that an emergency breakaway can be undertaken by a crew. Dispatchers should still be deploying the nearest and most appropriate resource.

2.4.12. Upon agreement to breakaway, the new incident must be assigned to the attending crew and notes added to the Computer Aided Dispatch (CAD) notes.

2.4.13. Depending on the advice provided by the on-scene clinician, a decision can be made to activate a further resource to the patient being left or dual assign the vehicle if they wish to return to the original call. It may be

necessary to return the ongoing call to the dispatch stack, with appropriate notes.

2.4.14. **The dispatch team or specialist resource desk can make a shared decision on multi-assigning the incident or removing the original crew from the incident by clicking the stand down before arrival status.**

2.4.15. **The dispatch team or specialist resource desk must ensure the original incident is not cancelled by the crew and ensure the incident is either back in the dispatch waiting list or multi assigned.**

2.4.16. All breakaways must have the **short code '/Break' Breakaway Completed** to confirm this action has been accurately recorded on the CAD.

2.4.17. Examples of outcomes could include:

- The clinician has completed an assessment, and a further resource is required to transport the patient as a Grade 4.
- The clinician has completed an assessment and will return once the emergency breakaway is complete.
- The patient can be discharged from scene and can make own way to Hospital or Urgent Treatment Centre.
- The patient can be discharged from scene. Out of service time will need to be made available to complete patient documentation later.
- This list is not exhaustive

2.4.18. If the incident still requires the attendance of a resource once a breakaway has occurred, the case will move back to the pending list and welfare calls will be completed in line with the Patient Welfare Call Procedure.

2.4.19. Whilst en-route to the new incident, if confirmed the specialist resource is no longer required or the incident is no longer a confirmed cardiac arrest and downgraded, EOC should stand-down the resource and return them to their original incident. The end of shift arrangements will not apply in this scenario.

2.4.20. If the clinician needs to return to the original patient, this should be completed before being assigned to further incidents.

2.4.21. If the original crew cannot return, another suitable resource should be sent at the earliest opportunity in line with Ambulance Response Programme (ARP) guidelines.

2.4.22. **Clinician actions in response to an emergency breakaway**

2.4.23. Clinicians must consider carefully whether it is appropriate to carry out an emergency breakaway.

2.4.24. More information may be sought from EOC so an informed decision can be made.

2.4.25. Upon being notified of an emergency breakaway requirement, the attending clinicians should make a dynamic risk assessment and have completed an appropriate focused clinical assessment to ensure the patient is stable. An emergency breakaway must not be completed until the focused clinical assessment has been completed and documented.

2.4.26. This process will be completed far more quickly than a standard assessment, referral, or discharge.

2.4.27. The patient must be informed of the decision to leave.

2.4.28. The clinician must provide sufficient explanation to the patient that their care will continue after the emergency breakaway (unless being discharged).

2.4.29. The patient should be given worsening care advice to call the Ambulance Service on 999 if they experience any deterioration.

2.4.30. The patient must be provided with verbal worsening care advice and advised to call 999 if no contact has been made within one hour.

2.4.31. Where appropriate patients should be left in the care of a responsible person (i.e. carer or family member).

2.4.32. A patient clinical record must be completed with a minimum of any crew actions completed, such as treatment provided and basic observations. Hand written Patient Clinical Records (PCR) should be left with the patient. Any information recorded on an Electronic Patient Clinical Record (ePCR) can be accessed by further attending resources. If the original crew doesn't return, the new clinician attending must continue with the original documentation.

2.4.33. If the current patient is unhappy with the decision, the crew have the authority to leave when the clinical need is clearly justified.

2.4.34. Clinicians who have undertaken an emergency breakaway must be able to justify their rationale. Clinicians who feel it is unsuitable to leave their current patient should not breakaway.

2.5. **Specialist Deployment Requirements**

2.5.1. All specialist resources are required to follow the same principles, ethical viewpoint and breaking away procedure for specialist deployments.

2.5.2. **SORT**

2.5.3. Upon identification of a CBRN /Hazmat incident, or suspicion /declaration of an MTA incident or Operation PLATO being declared, there are

nationally mandated procedures with regards to mobilisation of SORT trained staff to an incident, these are as follows:

Total of 10 x SORT staff within 10 minutes

Total of 20 x SORT staff within 20 minutes

Total of 35 x SORT staff within 30 minutes

2.5.4. The first SORT staff mobilised to an incident should be those on frontline vehicles. The second wave of mobilisation should be staff who are on duty but not logged on.

2.5.5. Please refer to the SORT Deployment Procedure for further guidance.

2.5.6. **HART**

2.5.7. Upon receiving a HART mobilisation requirement, the following response standards are required:

2.5.8. 4 HART personnel must be available or released and mobilised to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.

2.5.9. Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.

2.5.10. When HART are on scene and confirmation this is a HART incident, the remaining 2 members of the team working on the primary response vehicles are required to mobilise within 10 minutes.

2.5.11. Attendance at strategic sites of interest should have a response on scene within 45 minutes.

2.5.12. For mutual aid requests, HART have 30 minutes to deploy.

2.5.13. Please refer to the HART deployment procedure for further guidance.

2.5.14. **CCP**

2.5.15. Emergency breakaway is available for CCP deployments when already engaged on an emergency call.

2.5.16. Emergency breakaway does not apply if other resources are on scene. It would be for the CCP to decide if clinically they are able to leave scene.

2.5.17. CCPs will routinely provide a clinical update to the CCD shortly after arrival, should the CCP not be required, and the patient can safely be left with other clinicians on scene they will declare themselves ‘delayed

available'. Only CCPs who have informed the CCD they are available should be contacted for a breakaway request.

2.5.18. CCPs should follow the same principles, ethics and procedures laid out in this document.

2.5.19. Please refer to the Critical Care Desk Policy and Procedure for further guidance.

3 Definitions

3.1. *Dynamic Risk Assessment* – The continuous process of identifying hazards, assessing risk, taking action to eliminate or reduce risk, monitoring and reviewing, in the rapidly changing circumstances of an operational incident

3.2. EOC – Emergency Operations Centre

3.3. APP – Advanced Paramedic Practitioner

3.4. CCP – Critical Care Paramedic

3.5. PCR – Patient Clinical Record

3.6. ePCR – Electronic Clinical Patient Record

3.7. SRV – Single Response Vehicle

3.8. DCA – Double Crewed Ambulance

3.9. CAD – Computer Aided Dispatch

3.10. HCP – Health Care Professional

3.11. MDT – Mobile Data Terminal

3.12. RD – Resource Dispatcher

3.13. DTL – Dispatch Team Leader

3.14. SORT – Specialist Operations Response Team

3.15. HART – Hazardous Area Response Team

3.16. UCH – Urgent Care Hub

3.17. PACCS – Pathways Clinical Consultation Support

3.18. ARP – Ambulance Response Programme

3.19. Grade (2,3,4) – Priority grading back-up criteria

4 Responsibilities

4.1. The **Chief Executive Officer** is responsible for safe and effective care for patients.

4.2. The **Executive Director of Operations** is responsible for implementing the procedure.

4.3. **The Director of Nursing** is responsible for monitoring and auditing this process, and for providing assurance of patient safety and measures to prevent harm.

4.4. **Operational Managers and Consultant Paramedics** are responsible for upholding the principles and processes outlined in this procedure.

4.5. **Operational Team Leaders and Dispatch Team Leaders** are responsible for managing the procedure.

4.6. **All Operational Staff** are responsible for adoption and use of this procedure.

5 Audit and Review (evaluating effectiveness)

5.1. This procedure will be reviewed at the following intervals:

- End of week one
- End of first month
- End of six month
- End of first year

5.2. Reviews will include any feedback from staff, Datix (DIF1) submitted, complaints, and serious incidents.

5.3. During the review period, all emergency breakaways will be audited to ensure patient safety.

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

5.5. 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).

5.6. 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.

5.7. 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. Clinical Audit Procedure

6.2. Discharge Procedure

6.3. Driving Standards Policy

6.4. Driving Standards Procedure

6.5. Incident Resourcing, Deployment & Management Procedure

6.6. Incident Reporting Policy (DATIX) & Procedure

6.7. Medical Passengers Policy

6.8. Paper PCR Operational Completion & Submission Procedure

6.9. Referral Discharge and Conveyance Policy

6.10. Risk Management Procedure

6.11. Referrals Procedure

6.12. Risk Management Policy

6.13. Safeguarding Policy & Procedure for Children, Young People and Adults

6.14. Scope of Practice and Clinical Standards Policy

6.15. SORT deployment Procedure

6.16. Surge Management Plan

7 References

7.1. HCPC – Standards of Performance, Conduct and Ethics

7.2. HCPC – Standards of Proficiency: Paramedics

7.3. NHS England: Health & Social Care Act

7.4. NHS England: 5 Year Forward View

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.