South East Coast Ambulance Service NHS
NHS Foundation Trust

Scope of Practice and Clinical Standards Policy

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Equality Analysis Record

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Contents

1 Statement of Aims and Objectives

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 have the skills, knowledge and equipment in order to confidently and competently care for our patients/populations. The purpose of this policy is to provide clear guidance for all grades of patient-facing staff of the scope and breadth of their practice and professional development.

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.

The main principles underpinning the document are:

1.1. To provide instruction for staff to ensure they practice within clear boundaries.

1.2. To provide a framework which demonstrates that our Trust provides staff with the appropriate authority, supervision and training to meet the needs of our patients.

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

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.

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 must include.

This document contributes to the maintenance of the standards we set ourselves and those that are required contractually or from national performance standards.

This document will define clearly those standards for staff and minimise clinical error by ensuring staff work within their scope and competency, and to required quality standards. The policy outlines the importance of promoting a Learning Culture in our Trust, and how the standards related to scope of practice can be observed in order to uphold patient safety and quality of care.

2 Principles

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

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

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

2.4. Staff are required to provide care at an acceptable standard and this policy describes those core standards and the need for staff to practice in line with these requirements.

2.5. The Trust reserves the right to monitor and performance-manage staff in order to maintain their scope of practice and clinical standards.

2.6. The management of risk and evidencing of a governance-led approach to how the Trust plans and delivers care is vital, and the Trust is committed to ensuring that this is always paramount.

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

2.7.1. 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.

2.7.2. Senior/specialist paramedics (Paramedic Practitioners (PPs) and Critical Care Paramedics (CCPs)) are allocated 130 hours per year of Skills Assurance Time, which taken in a range of appropriate supervised clinical environments and follows competency and curriculum documents to provide ongoing evidence of competency with the senior paramedics' scope of practice.

2.7.3. 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.

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

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

2.8.1.1. Inability due to lack of 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.

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

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

2.8.2. Cases may also be dealt with using the disciplinary procedure and/or capability procedure.

2.8.3. Each case will be independently reviewed, however staff should be aware that operating below or beyond their scope of practice could result in action under the capability procedure and/or disciplinary procedure and referral to a professional body (Health and Care Professions Council, Nursing and Midwifery Council or General Medical Council).

2.8.4. Procedures carried out outside scope of practice may be considered as assault, whether consent has been obtained or not, and the Trust may report incidents to the Police.

2.9. Amending the scope of practice

2.9.1. The scope of practice and clinical standards for each grade (see appendices) can only be amended following approval by the **New Interventions Sub-Group.** The purpose of these appendices is to set scope of practice and required level of clinical standards expected of clinical staff at all levels throughout the Trust, consistent with regulatory, professional or commissioned standards.

2.9.2. Trust clinicians must follow clinical guidelines issued. These will usually follow JRCALC, although the Trust may elect to use other evidence bases for practice, or authorise practice as part of appropriately authorised research.

2.9.3. The **New Interventions Sub-Group** is authorised to approve the addition, removal and amendment of the appendices of this document which relate to individual clinical grades. This will allow more rapid updating of the document.

2.10. Guiding principles

2.10.1. The specific skills and drugs for each grade of clinician can be found in the appendices. However, there are guiding principles and standards of proficiency that relate to all clinicians employed by or working on behalf of the Trust. These standards of proficiency are similar to those expected of paramedics by the HCPC and can be found in the HCPC standards of proficiency document. The following principles relate to the grade at which the individual clinician is working and draws heavily from the HCPC guidelines.

2.11. **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).

2.12. **All Trust clinicians must:**

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

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

2.12.3. Maintain confidentiality.

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

2.12.5. Exercise a duty of care.

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

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

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

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

2.13. **Inter-disciplinary relationships:** All Trust clinicians must:

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

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

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

2.13.4. 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.

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

2.14.1. Be able to gather appropriate information.

2.14.2. Be able to use appropriate assessment techniques.

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

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

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

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

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

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

2.16.2. 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.

2.16.3. 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 don't lead to secondary illness (i.e. infection from poor aseptic technique or skin ulceration from inappropriate immobilisation on a spinal board).

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

3 Definitions

3.1. **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.

3.1.1. When referring to scope of practice, this document specifically means the scope of practice expected of clinicians working for the Trust, either as an employee or other agent (such as Voluntary Aid Societies or Community First Responders); from herein will be referred to as "staff".

3.2. **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.

3.3. **Medicines Formulary.** Appendix M of this document lists the medicines authorised for possession and use by Trust clinicians. 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.

4 Responsibilities

4.1. The **Chief Executive** has ultimate responsibility for Scope of Practice & Clinical Standards.

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

4.3. The **Consultant Paramedic/Head of Clinical Development** and **senior Operations Directorate Managers** are responsible for overseeing the policy on a day-to-day basis.

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

4.5. **All Trust clinicians** are responsible for observing the scope of practice and clinical standards commensurate to their clinical grade

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

4.6.1. Safeguarding

4.6.2. Mental capacity

4.6.3. Infection control

4.6.4. Medicine Management

4.6.5. Information Governance and Caldicott guardianship

5 Competence

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

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

6 Monitoring

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

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

6.2.1. This may include reports received via Patient Advice and Liaison Service (PALS), IWR-1 incident reports or verbal reports from staff.

6.3. 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.

6.4. Changes to specific appendices must be reviewed by the Joint Partnership Forum prior to approval.

7 Audit and Review

7.1. 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.

8 Associated Documentation

8.1. Referral, Discharge and Conveyance Policy

8.2. Discharge Procedure

8.3. Referrals Procedure

8.4. Conveyance, Handover and Transfers of Care Procedure

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

8.6. Capability Policy.

8.7. Disciplinary Policy.

8.8. Community Responder Strategy & Scope of Practice guidelines.

8.9. Recruitment & Selection Policy.

8.10. Medical Devices Management Policy.

8.11. Risk Management Training Procedure.

8.12. Implementing New Guidelines Policy & Procedure.

8.13. Job Descriptions for roles.

8.14. Infection Prevention and Control Policy.

8.15. Clinical Supervision Policy

8.16. Professional Standards Policy

8.17. Health & Safety Policy

8.18. Minimal Moving and Handling Policy

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

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

9 References

9.1. Joint Royal Colleges Ambulance Liaison Committee (JRCALC)

9.2. Institute of Health Care Development paramedic manual, IHCD 2007

9.3. Institute of Health Care Development technician manual, IHCD 1999

9.4. Health Care and Professions Council standards documents

9.5. Nursing and Midwifery Council code and standards documents

9.6. General Medical Council: Standards Guidance for Doctors

Appendix A

This appendix is split in to two sections; A1 for Community First Responders, and section A2 for Immediate Emergency Care Responders from the Fire Service. They are both considered within the overarching provision of community responders within the Volunteer Services Department in the Clinical Operations Directorate.

Appendix A1: Community First Responder

Clinical Practice Areas
 	
Grade of Staff: **Community First Responders**
 	
Community First Responders fall into the following groups and have differing governance arrangements dependant on the organisation they are from:
 	
• SECAmb trained lay-responders who do not hold a formal clinical qualification
  ○ These CFRs practice under SECAmb governance processes and their definition of practice is detailed in the Responder Policy
 	
• SECAmb approved CFRs who are healthcare professionals
• SECAmb staff responders
  ○ These staff operate at their usual scope of practice and are denoted by a “R-romeo” call sign
 	
• Non SECAmb responders
  ○ These staff such as Doctors, Nurses or Paramedics from other organisations operates to a scope of practice agreed with SECAmb – broadly aligned to an appropriate equivalent SECAmb scope of practice.
  ○ This is to ensure that our patients benefit in a safe way from responders with existing advanced skills and experience.
 	
• Voluntary Aid Services
	Comments/Notes

	○ VAS (specifically the British Red Cross Society and St John Ambulance Brigade) operate within limits set with operational memorandums of understanding and reference the organisations own governance frameworks • Co-responders, such as Fire & Rescue Services, Coastguard etc. ○ Co-responders from other agencies operate to training levels set within their own organisation by agreed with SECAmb. **Non SECAmb staff responders will always be backed up to 999 calls immediately and cannot make conveyance decisions.** The following information relates only to SECAmb-trained, lay-responders.	
1.	**Responsibility** 1.1. Respond as a first responder to any emergency call other than: • Fire • Severe Trauma • Spinal Injuries • Road Traffic Accidents • Industrial Accidents • Any incident involving abuse/violence or aggression • Alcohol or drug related incidents including overdoses, except where the • overdose is unintentional by a minor • Maternity or Gynaecological emergencies 1.2. Community First Responders must not under any circumstances respond using blue lights or sirens. 1.3. CFRs have a responsibility and duty of care to provide a high standard of care commensurate to their skill set.	

2.	**Skill set**	
	2.1. Primary Survey only 2.1.1. Community responders will not be required to examine intimate areas of a patient, except where not doing so would put the patient at further risk. 2.1.2. Community responders will not carry out any invasive[1] or internal[2] examinations or procedures 2.2. Administration of specified medications (see list below) 2.3. Semi-automatic defibrillation 2.4. Basic Life Support 2.5. Assisting other clinicians in carrying out Advanced life support (RCUK/ERC Guidelines) – Adult, Child, Infant, Newborn 2.6. Approved equipment list 2.6.1. CFRs must only utilise clinical equipment and consumables as stated in the Responder Policy 2.6.2. CFRs must not work outside their Scope of Practice in relation to equipment or consumables. 2.6.3. Any local agreements must be in place with the Voluntary Services Department relating to any pre-existing equipment owned by a CFR scheme, not currently on the approved	

[1] Invasive procedures can be defined at those which require interrupting the continuity of skin or insertion into body cavities (excluding the oral or nasal cavity)
[2] Internal & intimate examinations relate specifically to rectal or vaginal investigations.

	equipment list. 2.6.4. The Clinical Quality Working Group will approve or reject any additional equipment proposed for inclusion as part of the Approved Equipment List or Local Agreements. 2.6.5.	
3.	**Referral rights**	
	3.1. Community First Responders must always seek to hand-over patients to qualified operational Ambulance Personnel. 3.2. CFRs must be backed up with qualified operational Trust staff when attending emergency calls. 3.2.1. It is accepted that in exceptional circumstances, back-up may be delayed or not be possible (i.e. adverse weather) 3.3. CFRs cannot stand down other resources 3.4. CFRs cannot make referrals to other health professionals. Any referrals will be made by the operational clinician(s) attending the incident, or in EOC. 3.5. CFRs are not authorised to discharge patients. In exceptional circumstances, a discharge decision may be made by a clinician remotely, but this must not be considered routine 3.6. CFRs cannot make conveyance decisions and must defer to the attending clinician(s).	

4.	Drugs and preparations authorised for use	
	4.1. JRCALC Drugs[3] or other medicines authorised by the Trust. 4.1.1. **Please refer to Appendix M** 4.2. PGDs 4.2.1. Lay CFRs are not registered health professionals and therefore not legally entitled to issue drugs under a patient group direction 4.3. Medicine management responsibilities 4.3.1. CFRs are responsible for the safe keeping of medications in their possession and must report damage, theft or losses. 4.3.2. Use of medicines must be recorded on the PCR on arrival of SECAmb clinician, and must include the CFRs unique PP Number 4.3.3. CFRs must record all drug administration on their Drugs Issue Card (see Medicines Management Manual) 4.4. Medicines administration responsibilities 4.4.1. Medicines must only be administered at the dose stated and via the route stated in the	

[3] JRCALC Drugs are authorised for use via legal mechanisms (depending on grade) – see Appendix M for information.

	CFR medicines Prompt Card. 4.4.2. CFRs cannot deviate from training. 4.4.3. CFRs must act as the patients advocate and must make any concerns known to others involved in patient care where a potential and/or imminent drug error could occur.	
5.	**Supervision**	
	5.1. Supervises: 5.1.1. Community responders do not provide formal supervision, but may provide mentorship and support to new members of the Community First Responder scheme 5.1.2. Community responders may also provide supervision as part of a training action plan. 5.2. Supervised by: 5.2.1. CFR Team Leader 5.2.2. CFR Senior Team Leader 5.2.3. CFR Associate Trainer 5.2.4. CFR Senior Associate Trainer 5.2.5. SECAmb Operational clinicians and managers. 5.2.6. Volunteer Development Coordinators	
6.	**Documents related to grade**	
	6.1. JRCALC Clinical Practice Guidelines 6.2. Resuscitation Guidelines 6.3. CFR Drugs Prompt Card 6.4. CFR Foundation Course 6.5. CFR Drug Issue Card	
7.	**Pre-requisites for continued voluntary membership of CFR scheme**	

	7.1. DBS on appointment 7.2. Occupational health check on appointment 7.3. Full, valid UK driving licence held for at least 12 months (up to 3 penalty points) 7.3.1. Appropriate insurance for vehicle being used for responding as a CFR 7.4. Up to date evidence for right to work and reside in the UK. 7.5. References. 7.6. Evidence of competency through Trust-approved process	
8.	**Specialist Roles and Special Conditions**	
	8.1. CFRs do not have any specialist roles or conditions	

Appendix A2: Immediate Emergency Care Responders (IECR) (Fire Service)

Clinical Practice Areas	

Grade of Staff: **Immediate Emergency Care Responder (IECR)**
 	
Background of personnel
 	
Firefighters are familiar with dealing with emergency situations, and are ideally placed to support SECAmb in a limited number of clinical presentations. Firefighters are not registered health professionals, and are therefore not familiar with the day to day delivery of clinical services. This appendix describes the scope of practice required to facilitate the benefits of IECR, and to ensure that patient care and safety is optimised.
 	
Operational deployment
 	
IECR is a different system to other co-responding schemes involving Fire & Rescue Services (FRS) due to having a wider scope of practice than a standard CFR or co-responder, and they can also use their care skills in their own organisation. They also respond to incidents under emergency conditions. Previous and current schemes across the region use personnel from other services, such as FRS, but in a traditional Community First Responder mode. These include;
 	
• Fire & Rescue Services, Coastguard etc.
 	
  ○ Co-responders from other agencies operate to training levels set within their own organisation by agreed with SECAmb.
 	
  ○ Immediate Emergency Care (IEC) is based on a national profile and SECAmb has added the CFR aspect (IECR) to this in order to make it fit for purpose locally.
 	
• IECRs will always be backed up to 999 calls immediately and cannot make conveyance
	Comments/Notes

decisions.

- The following information relates only to SECAmb-trained and approved IECR schemes operating within the Trusts geographical boundaries, or within cross-border agreements with neighbouring Trusts. Due to the FRS's position within mutual aid arrangements, IECRs are permitted to use their additional care skills if required when operating outside SECAmb area, but only in order to save lives.

- IECR has two modes of mobilisation; SECAmb and FRS. When responding to incidents originating from FRS, IECRs are authorised to use their care skills under the SECAmb governance arrangements.

9. Responsibility

9.1. Respond as a first responder to any emergency call other than (and with the exception of incidents suggestive of including cardiac arrest of clear threat to life):

- Any incident involving abuse/violence or aggression
- Alcohol or drug related incidents including overdoses, except where the overdose is unintentional by a minor
- Maternity or Gynaecological emergencies
- Incidents involving mental health crises

9.2. IECRs have a responsibility and duty of care to provide a high standard of care commensurate to their skill set.

9.3. IECRs will document any treatment provided on SECAmb patient clinical record (PCR) documents. Any PCRs started by an IECR must be handed to the attending SECAmb clinician on their arrival as part of the formal handover process

9.3.1. IECRs/FRS's will not retain any patient identifiable information relating to

	patient contacts. It is accepted that FRS's collect demographic information relating to 999 callers, but clinical records must be managed by SECAmb. 9.4. **Media/Press enquiries** 9.4.1. All media enquiries which involve the care skills delivered by IECRs MUST be referred to the SECAmb Communications Team. FRS's are not authorised to make comments on clinical care for patients attended by SECAmb, or under the governance of the IECR scheme	
10.	**Skill set**	
	10.1. The Scope of Practice for IECRs has been broken down into three areas; 10.1.1. Directly applied interventions (i.e. oxygen therapy) 10.1.2. Interventions assisted (i.e. assisting paramedic with applying splintage) 10.1.3. Interventions they are given awareness of only (i.e. chest drainage) 10.2. Primary Survey 10.2.1. IECRs will not be required to examine intimate areas of a patient, except where not doing so would put the patient at further risk. 10.2.2. IECRs will not carry out any invasive[4] or internal[5] examinations or procedures	

[4] Invasive procedures can be defined at those which require interrupting the continuity of skin or insertion into body cavities (excluding the oral or nasal cavity)
[5] Internal & intimate examinations relate specifically to rectal or vaginal investigations.

	10.3. Administration of specified medications (see appendix M) 10.4. Semi-automatic defibrillation 10.5. Basic and Intermediate Life Support 10.6. Assisting other clinicians in carrying out Advanced life support (RCUK/ERC Guidelines) – Adult, Child, Infant, Newborn 10.7. Approved equipment list 10.7.1. IECRs must only utilise clinical equipment and consumables as stated in appendix 5 within the Memorandum of Understanding with each FRS 10.7.2. IECRs must not work outside their Scope of Practice in relation to equipment or consumables and must follow directions given by a healthcare professional (i.e. paramedic) at all times. 10.7.3. The Clinical Quality Working Group will approve or reject any additional equipment proposed for inclusion as part of the Approved Equipment List within appendix 5 of the MoU.	
11.	**Referral rights**	
	11.1. IECRs will always seek to hand-over patients to qualified operational Ambulance Personnel. 11.2. IECRs must be backed up with qualified operational Trust staff when attending emergency calls. 11.2.1. It is accepted that in exceptional circumstances, back-up may be delayed or not be possible (i.e. adverse weather) in which case, telephone support will be provided 11.2.2. The MoU provides information on when and how to contact the SECAmb clinical support desk in the event of delayed or unavailability of back up 11.3. IECRs cannot stand down other resources 11.4. IECRs cannot make referrals to other health professionals. Any referrals will be made by the operational clinician(s) attending the incident, or in EOC. 11.5. IECRs are not authorised to discharge patients. In exceptional circumstances, a discharge	

	decision may be made by a clinician remotely, but this must not be considered routine 11.6. IECRs cannot make conveyance decisions and must defer to the attending clinician(s). Patients must not be transported to hospital in FRS vehicles unless specifically agreed by a SECAmb clinician and only where there is sufficient insurance by the FRS to facilitate patient movements. FRS patient movements would also be considered an exceptional event and would require completion of an IWR-1 and Bronze level investigation 11.6.1. In the unlikely event of FRS patient transportation, a PCR must have been completed by a SECAmb clinician prior to the patient leaving scene.	
12.	**Drugs and preparations authorised for use**	
	12.1. JRCALC Drugs[6] or other medicines authorised by the Trust. 12.1.1. **Please refer to Appendix M** 12.2. PGDs 12.2.1. IECRs are not registered health professionals and therefore not legally entitled to issue drugs under a patient group direction	

[6]JRCALC Drugs are authorised for use via legal mechanisms (depending on grade) – see Appendix M for information.

	12.3. Medicine management responsibilities 12.3.1. IECRs are responsible for the safe keeping of medications in their possession and must report damage, theft or losses. 12.3.2. Use of medicines must be recorded on the PCR on arrival of SECAmb clinician, and must include the IECRs unique identity number 12.3.3. IECRs must record all drug administration on their Drugs Issue Card (see Medicines Management Manual) 12.4. Medicines administration responsibilities 12.4.1. Medicines must only be administered at the dose stated and via the route stated in the IECR medicines Prompt Card. 12.4.2. IECRs cannot deviate from training. 12.4.3. IECRs must act as the patients advocate and must make any concerns known to others involved in patient care where a potential and/or imminent drug error could occur.	
13.	**Supervision**	
	13.1. Supervises: 13.1.1. IECRs do not provide formal supervision, but may provide mentorship and support to new members of the IECR scheme 13.1.2. IECRs may also provide supervision as part of a training action plan. 13.2. Supervised by: 13.2.1. FRS IECR Train the Trainer Leads 13.2.2. SECAmb Operational clinicians and managers. 13.2.3. Volunteer Development Coordinators	
14.	**Documents related to grade**	
	14.1. JRCALC Clinical Practice Guidelines 14.2. Resuscitation Guidelines 14.3. IECR Drugs Prompt Card	

	14.4. IECR Curriculum 14.5. IECR Drug Issue Card	
15.	**Pre-requisites for continuing practice within IECR scheme**	
	15.1. DBS on appointment 15.2. Occupational health check on appointment 15.3. References. 15.4. Evidence of competency through Trust-approved process	
16.	**Specialist Roles and Special Conditions**	
	16.1. IECRs are authorised to use their enhanced care skills on incidents not originating from a 999 call to SECAmb 16.2. In these circumstances where care is instigated, SECAmb attendance must be requested.	

Appendix B1 and B2: (removed from document)

Appendix C: Emergency Care Support Worker

Clinical Practice Areas Grade of Staff: **Emergency Care Support Worker (ECSW)** The ECSW role is intended to be one that is supervised by a paramedic in the emergency response role. ECSWs can, in exceptional circumstances respond solo, but do so under the scope of practice of a Community First Responder. ECSWs can work as a crew with another ECSW on Intermediate Tier Vehicles. When working on an Intermediate Tier Vehicles they work with another ECSW to undertake planned transfer work. ITV work is considered supervised, as the patient has already received a diagnosis (working or definitive) and requires only high standards of care and monitoring whilst en-route to a pre-planned care facility. This includes patients who are being taken to hospital as an HCP call, or 999 calls which are being conveyed by ITV as a delayed conveyance. ITVs may in exceptional circumstances be tasked as a primary response to 999 calls, and the Scope of Practice when doing so remains that of a Community First Responder in broad terms, but some exemptions exist to ensure that when working without direct clinical supervision, observations can be carried out.	**Comments/Notes**
1. Responsibility	
1.1. **Work in line with the Trust Job Description for the role and adhere to any conditions.** 1.2. Provide emergency response 1.3. Crew response (DCA) 1.4. A&E duties 1.5. PTS duties 1.6. Intermediate Tier Vehicle duties (see ITV procedure document)	

	1.7. Maintain and be able to produce evidence of Continuous Professional Development	
2.	**Skill set**	
	2.1. Primary and Secondary Survey`s 2.1.1. ECSWs will not be required to examine intimate areas of a patient, expect where not doing so would put the patient at further risk. ECSWs will not carry out any invasive or internal examinations or procedures 2.1.2. ECSWs may be required to assist paramedics with intimate or invasive procedures (such as administration of rectal diazepam, or assisting with childbirth) 2.2. Undertake clinical observations 2.2.1. ECSWs are authorised to carry out non-invasive clinical observations on patients when working the ITV role, or when making a first-response to a 999 call. 2.2.1.1. The intention of permitting ECSWs to carry out observations when attending 999 calls is to ensure that once back-up arrives, a more complete handover can be undertaken. 2.2.1.2. Please refer to 2.2.3 2.2.1.3. This does not extend any treatments available beyond those available to CFRs, as per Appendix M. 2.2.2. ECSWs may carry out: 2.2.2.1. Manual or automatic blood pressure measurement 2.2.2.2. Pulse oximetry 2.2.2.3. 12 Lead ECG 2.2.2.4. Thermometry 2.2.2.4.1. Blood glucometry 2.2.3. ECSWs are not authorised to make clinical decisions based on these values, except in an emergency situation, or following discussion with the Clinical Desk or the originating clinician to adjust treatments based on specific values (i.e. changes to oxygen therapy in response to changes in saturation reading). 2.3. Administration of specified medications (see list below) 2.3.1. Depending on whether working under supervision or solo/double ECSW	

	2.3.1.1. ECSWs may use medicines indicated in Appendix M for use by ECSWs only when receiving direct supervision 2.3.1.2. When responding solo (in exceptional circumstances) or attending a 999 call as a first response when working on an ITV, only medicines indicated for use by CFRs in Appendix M can be used, until back up arrives. 2.4. Defibrillation using automated external defibrillator only (not manual) 2.5. 3 &12 lead ECG acquisition 2.6. Basic Life Support & Intermediate Life Support 2.7. Assisting other clinicians in carrying out Advanced life support (RCUK/ERC Guidelines) – Adult, Child, Infant, Newborn 2.8. Patient immobilisation skills, under supervision from technician or above. 2.9. Care of Intravenous fluids / lines whilst on route to a care facility 2.10. Advanced driving (Blue light) 2.10.1. When responding solo (or as a double ECSW crew) as a first response to 999 calls, ECSWs can respond using blue lights and sirens, but must be backed up immediately. 2.10.2. The decision by EOC to send a solo response must fulfil the following criteria 2.10.2.1. There is a life-threatening call with no response assigned or available 2.10.2.2. There is no other member of staff available that can accompany the ECSW 2.10.2.3. Measures have been taken to locate resources (such as all calls to ambulances at hospital) 2.10.3. Instances of ECSW solo or double crewed ECSW emergency responses will be monitored by EOC and reported to the Duty Bronze manager who will contact the Duty Dispatch Manager to ensure that conditions listed above were met and the response was justified and appropriate. 2.10.3.1. A report will be sent to the Senior Clinical Operations Team meetings will all instance of Solo or Double crewed ECSW response. 2.10.3.2. These reports are not required for planned work or providing backup within the role of the	

	Intermediate Tier Vehicle system 2.10.4. Solo response of an ECSW to an emergency call will be considered an extraordinary event and will require investigation to ensure that the criteria is met, except: 2.10.5. Where a member of staff or manager who holds an ECSW level qualification has a strategic or tactical requirement to respond. This does not alter any other aspect of the ECSW scope of practice. 2.10.6. ECSWs do not require supervision when driving. 2.11. Manual Handling	
3.	**Referral rights**	
	3.1. Emergency Care Support Workers should only be deployed with a suitably qualified and experienced clinician. Therefore, should not need to refer. However, under exceptional circumstances where an ECSW has attended an incident alone they must always refer the patient onto a suitably qualified clinician such as Technician, Paramedic, PP, CCP etc. ECSWs adopt the scope of practice of a CFR when responding solo, and this includes the principles associated with referral and discharge (please refer to the CFR appendix). When working on an Intermediate Tier Vehicle, there should be no requirement to refer as the work undertaken will be planned and the patients' needs already agreed.	
4.	**Drugs and preparations authorised for use under supervision or when working as an ITV (solo response covered as per the CFR scope of practice)**	
	4.1. JRCALC Drugs 4.1.1. **Please refer to Appendix M** 4.1.2. Special instruction regarding Oxygen 4.1.2.1. Oxygen does not require supervision in an emergency 4.1.2.2. Patients on long term oxygen therapy must not have their oxygen flow increased, unless in	

	an emergency. 4.2. PGDs 4.2.1. ECSWs are not registered health professionals and therefore not legally entitled to issue drugs under a patient group direction 4.3. Medicine management responsibilities 4.3.1. ECSWs are responsible for the safe keeping of medications in their possession and must report damage, theft or losses. 4.3.2. Use of medicines must be recorded on patient documentation provided. 4.3.3. ECSWs are required to complete Patient Clinical Records legibly. 4.3.4. ECSWs are required to complete any drug audits. 4.4. Medicines administration responsibilities 4.4.1. Medicines must only be administered in the dose stated and via the route stated. 4.4.2. ECSWs cannot deviate from training. 4.4.3. ECSWs must act as the patients advocate and must make any concerns known to others involved in patient care where a potential and/or imminent drug error could occur. 4.5. ECSWs can assist Technicians, Paramedics and Drs with the preparation and administration of other drugs only under direction of that clinician. 4.5.1. “Preparation” is defined as the assembly of syringes/needles, and the selection and checking of medicines (where legally appropriate, i.e. controlled drugs). 4.5.2. “Administration” is defined as giving the drug via the route intended (i.e. oral, IM, IV etc.) 4.5.3. “Under direction” is defined as: directly supervised by the clinician responsible for the patient and/or the medicine, and to the exclusion of all other tasks (i.e. the paramedic cannot direct administration whilst driving the ambulance)	

5.	**Supervision**	
	5.1. Supervises: 5.1.1. ECSW do not provide managerial supervision in their clinical role. It is recognised there are managers within the Trust who hold the clinical grade of ECSW. 5.1.2. Specific guidance in relation to situations where an undergraduate student paramedic is on placement in SECAmb. 5.1.2.1. Student paramedics are encouraged to remain with the patient en-route to hospital, and this may mean whilst the patient is being monitored by an ECSW. 5.1.2.2. ECSWs have no supervisory role in these circumstances and must not permit the student paramedic to undertake and interventions/skills 5.1.2.3. The paramedic supervisor remains responsible for the student paramedic at all times, and if they elect to drive the ambulance must ensure that the ECSW is not supervising or permitted interventions by the student paramedic 5.2. Supervised by: 5.2.1. Paramedics (Inc. PPs & CCPs) 5.2.2. Clinical Team Leader 5.2.3. Clinical Operations Managers 5.3. ECSWs provide support to any higher grade of staff working with them. This allows ECSWs to work alongside Technicians in order to uphold their duty of care to promote safe patient care.	
6.	**Documents related to grade**	
	6.1. JRCALC Clinical Practice Guidelines	
7.	**Pre-requisites for continued employment**	
	7.1. DBS on appointment 7.2. Occupational health check on appointment	

	7.3. Full, valid UK driving licence (up to 9 penalty points; will be monitored by line manager) 7.4. Up to date evidence for right to work and reside in the UK. 7.5. Maintain and be able to produce evidence of Continuous Professional Development	
8.	**Specialist Roles and Special Conditions**	
	8.1. Under exceptional circumstances an ECSW may be tasked to incidents alone as a last resort and this must not be a pre-planned deployment. 8.2. ECSWs may be asked to crew CCP ambulances with a qualified CCP. This does not extend the ECSW scope of practice, but will expose them to higher acuity patients.	

Appendix C2: Associate Practitioner

Clinical Practice Areas Grade of Staff: **Associate Practitioner** Staff who operate at the Associate Practitioner grade (including Trainee Paramedics*) must be either enrolled, or preparing to enrol, in a recognised paramedic science education programme. This clinical grade is based largely on the Technician scope of practice and is provided as an extended role for Emergency Care Support Workers who are developing towards a paramedic science award. It excludes ALL additional skills associated with Advanced Technicians. The Associate Practitioners role also has different requirements relating to the discharge of patients from scene and must be noted accordingly. ***The term paramedic is a legally protected professional title*** *Staff must not represent themselves as qualified paramedics or give patients/public any reason to suggest so, as this would contrary to the legal protection provided to the term "paramedic".*		**Comments/Notes**
1.	**Responsibility**	
	1.1. **Work in line with the Trust Job Description for the role and adhere to any conditions.** 1.2. Provide emergency response 1.3. Single response (car) 1.4. Crew response (DCA) 1.5. A&E duties 1.6. PTS duties 1.7. Maintain and be able to produce evidence of Continuous Professional Development (In line with University entry requirements and APEL (Accreditation of Prior Experiential Learning))	
2.	**Skill set**	

	2.1. Manual defibrillation 2.2. 12 lead acquisition 2.3. Advanced life support (RCUK/ERC Guidelines) – Adult, Child, Infant, Newborn 2.4. IM injections 2.5. Advanced driving (Blue light) 2.6. Manual Handling 2.7. Physical assessment skills at BTLS level (auscultation and percussion) 2.7.1. Associate Practitioners are permitted to visually examine intimate areas of a patient as part of essential care (such as childbirth). 2.7.2. Associate Practitioners will not carry out any intimate physical and/or internal examinations (rectal or vaginal) 2.7.3. Associate Practitioners may be required to assist paramedics with intimate or invasive procedures (such as administration of rectal diazepam) but not actually administering any medicines or performing treatment.	**Supporting document for section 2** Minimal Moving & Handling Policy Health & Safety Policy
3.	**Referral rights**	
	3.1. Conveyed patients 3.1.1. Unlimited authority to convey to hospital any patient calling 999. 3.1.2. Consideration must be given to advance directives or other care plans relating to preferred place of care 3.1.3. Authorised to convey to appropriate alternative facility (i.e. Minor injury unit) 3.2. Discharge and Referral 3.2.1. Associate Practitioners are encouraged to consider alternative care pathways 3.2.2. For non-conveyed patients the clinician is authorised to: 3.2.2.1. Refer patients back to their own GP 3.2.2.2. Refer patient to a specialist or advanced paramedic (i.e. PP)	

	3.2.2.3. Referral to community teams (either supported by PP or via local pathway arrangements) 3.2.3. For non-conveyed patients the clinician may not (depending on location) be authorised to: 3.2.3.1. Refer patients to Out of Hours providers. (This is due to contractual limitations relating to OOH providers taking referrals from non-registered clinicians – AP's can still contact the PP Desk to discuss care pathways and to arrange a PP referral if required in these situations) 3.3. For non-conveyed patients the Associate Practitioner is not authorised to: 3.3.1. Discharge patients from scene without first discussing with, and seeking agreement from, an appropriate registered clinician (usually, but not limited to, a PP or Clinical Supervision in EOC) even if the patient appears uninjured or without illness[7]. 3.3.1.1. All advice and follow-up details must be documented on the PCR 3.3.1.2. Where circumstances prevent contacting a clinician prior to discharge (i.e. due to unsafe environment) this must done as soon as possible after leaving the patients side, and prior to booking clear. Consideration must be given to a clinician calling the patient back in due course. 3.3.1.3. Where telephone contact is not possible, Associate Practitioners must request immediate clinician call-back via a radio call to their Dispatcher.	

[7] Unless the patient refuses care plan against the wishes of the crew, and has mental capacity.

	3.4. For all patients who are not conveyed, the following convention must be followed on the PCR/ePCR • Worsening care advice: Specific documented advice relating to anticipated signs or symptoms relating to their condition (i.e. headache, nausea etc.) • Safety netting: Specific documented advice relating to what to do if the patient worsens (i.e. push careline, call back on 999) • Left in care of: Who the patient is being cared for after discharge (if applicable) • Shared decision making: Who was liaised with and document agreed decision	
4.	**Drugs and preparations authorised for use**	
	4.1. JRCALC Drugs[8] **4.1.1. Please refer to Appendix M** ***4.1.2. There are certain parenteral medicines which must only be administered autonomously once the clinician has administered the drug five times under supervision from a paramedic (either on scene or via the clinical desk or PP desk)***	

[8] JRCALC Drugs are given under a set of specific POM (Prescription Only Medicine) Exemptions, issued by the MHRA.

	4.2. PGDs 4.2.1. Associate Practitioners are not registered health professionals and therefore not legally entitled to issue drugs under a patient group direction 4.3. Medicine management responsibilities 4.3.1. Associate Practitioners are responsible for the safe keeping of medications in their possession and must report damage, theft or losses. 4.3.2. Use of medicines must be recorded on patient documentation provided. 4.3.3. Associate Practitioners are required to complete Patient Clinical Records legibly. 4.3.4. Associate Practitioners are required to complete any drug audits. 4.3.5. Where an Associate Practitioners is the senior member of a crew, they are responsible for the recording of drug recording. 4.4. Medicines administration responsibilities 4.4.1. Medicines must only be administered in the dose stated and via the route stated. 4.4.2. Associate Practitioners cannot deviate from training. 4.4.3. Associate Practitioners must act as the patients advocate and must make any concerns known to others involved in patient care where a potential and/or imminent drug error could occur.	
5.	**Supervision**	
	5.1. Associate Practitioners do not supervise staff but have a duty of care to support staff in order to promote safe patient care. 5.2. First level supervised by: 5.2.1. Clinical Team Leader	

6.	**Documents related to grade**	
	6.1. JRCALC Clinical Practice Guidelines	
7.	**Pre-requisites for continued employment**	
	7.1. DBS on appointment 7.2. Occupational health check on appointment 7.3. Full, valid UK driving licence (up to 9 penalty points; will be monitored by line manager) 7.4. Up to date evidence for right to work in the UK. 7.5. Maintain and be able to produce evidence of Continuous Professional Development	
8.	**Specialist Roles and Special Conditions**	
	8.1. Single Response Vehicle working 8.1.1. Driver training 8.1.2. Lone working familiarisation 8.2. Associate Practitioners Officers/Managers 8.2.1. It is recognised that this group of staff operate predominantly in unmarked lease vehicles, which are not as fully kitted as an SRV. 8.2.2. The scope of practice for these staff is limited by the equipment they have in their vehicles when responding in them. 8.2.3. Officers/managers are required to be familiar with all equipment, drugs and vehicles commensurate to their grade.	

Appendix D: Ambulance Technician/Advanced Technician

Clinical Practice Areas Grade of Staff: **Technician** The Technician role (including Advanced Technician) includes ALL skills practiced at ECSW/Associate Practitioner grades. *n.b. Additional Advanced Technician skills are marked with an asterix*		**Comments/Notes**
9.	**Responsibility**	
	9.1. **Work in line with the Trust Job Description for the role and adhere to any conditions.** 9.2. Provide emergency response 9.3. Single response (car) 9.4. Crew response (DCA) 9.5. A&E duties 9.6. PTS duties 9.7. Maintain and be able to produce evidence of Continuous Professional Development	
10	**Skill set**	
	10.1. Manual defibrillation 10.2. 12 lead acquisition 10.3. Advanced life support (RCUK/ERC Guidelines) – Adult, Child, Infant, Newborn 10.4. IM injections 10.5. Advanced driving (Blue light) 10.6. Manual Handling 10.7. Physical assessment skills at BTLS level (auscultation and percussion) 10.7.1. Technicians and Advanced Technicians are permitted to visually examine intimate areas of	**Supporting document for section 2.1**1 Minimal Moving & Handling Policy Health & Safety Policy

	a patient as part of essential care (such as childbirth). 10.7.2. Technicians and Advanced Technicians will not carry out any intimate physical and/or internal examinations (rectal or vaginal) 10.7.3. Technicians and Advanced Technicians may be required to assist paramedics with intimate or invasive procedures (such as administration of rectal diazepam) but not actually administering any medicines or performing treatment.	
11	**Referral rights**	
	11.1. Conveyed patients 11.1.1. Unlimited authority to convey to hospital any patient calling 999. 11.1.2. Consideration must be given to advance directives or other care plans relating to preferred place of care 11.1.3. Consideration must be given to advance directives or other care plans relating to preferred place of care 11.1.4. Authorised to convey to appropriate alternative facility (i.e. Minor injury unit) 11.2. Discharge and Referral 11.2.1. Technicians are encouraged to consider alternative care pathways 11.2.2. For non-conveyed patients the clinician is authorised to: 11.2.2.1. Refer patients back to their own GP 11.2.2.2. Refer patient to a specialist or advanced paramedic (i.e. PP) 11.2.2.3. Referral to community teams (either supported by PP or via local pathway arrangements)	

	11.2.3. For non-conveyed patients the clinician may not (depending on location) be authorised to: 11.2.3.1. Refer patients to Out of Hours providers. (This is due to contractual limitations relating to OOH providers taking referrals from non-registered clinicians – Technicians can still contact the PP Desk to discuss care pathways and to arrange a PP referral if required in these situations) 11.3. For non-conveyed patients Technician/Advanced Technicians are not authorised to: 11.3.1. Discharge patients (over 12 years of age) with new/acute illness or injury without first discussing with, and seeking agreement from, an appropriate registered clinician (usually, but not limited to, a PP or Clinical Supervision in EOC). 11.3.2. Discharge can be undertaken without support where the patient has a clearly self-limiting condition requiring only simple advice or self-care treatments (i.e. low mechanism slip from chair, broken fingernail) and with no Red Flags (see Urgent Care Handbook for examples). **11.3.3. Instructions for when considering discharging children (12 and under): Please refer to the Discharge procedure** **11.3.4. Please refer to the guidance given in the Urgent Care Handbook** 1.1.1.1. All advice and follow-up details must be documented on the PCR 1.2. For all patients who are not conveyed, the following convention must be followed on the PCR/ePCR • Worsening care advice: Specific documented advice relating to anticipated signs or symptoms relating to their condition (i.e. headache, nausea etc.) • Safety netting: Specific documented advice relating to what to do if the patient worsens (i.e. push careline, call back on 999) • Left in care of: Who the patient is being cared for after discharge (if applicable) • Shared decision making: Who was liaised with and document agreed decision	

2.	**Drugs and preparations authorised for use**	
	2.1. JRCALC Drugs[9] **2.1.1. Please refer to Appendix M** 2.2. PGDs 2.2.1. Technicians are not registered health professionals and therefore not legally entitled to issue drugs under a patient group direction 2.3. Medicine management responsibilities 2.3.1. Technicians are responsible for the safe keeping of medications in their possession and must report damage, theft or losses. 2.3.2. Use of medicines must be recorded on patient documentation provided. 2.3.3. Technicians are required to complete Patient Clinical Records legibly. 2.3.4. Technicians are required to complete any drug audits. 2.3.5. Where a Technician is the senior member of a crew, they are responsible for the recording of drug recording.	

[9] JRCALC Drugs are given under a set of specific POM (Prescription Only Medicine) Exemptions, issued by the MHRA.

	2.4. Medicines administration responsibilities 2.4.1. Medicines must only be administered in the dose stated and via the route stated. 2.4.2. Technicians cannot deviate from training. 2.4.3. Technicians must act as the patients advocate and must make any concerns known to others involved in patient care where a potential and/or imminent drug error could occur.	
3.	**Supervision**	
	3.1. Technicians do not supervise staff but have a duty of care to support staff in order to promote safe patient care. 3.2. First level supervised by: 3.2.1. Clinical Team Leader	
4.	**Documents related to grade**	
	4.1. JRCALC Clinical Practice Guidelines	
5.	**Pre-requisites for continued employment**	
	5.1. DBS on appointment 5.2. Occupational health check on appointment 5.3. Full, valid UK driving licence (up to 9 penalty points; will be monitored by line manager) 5.4. Up to date evidence for right to work in the UK.	

	5.5. Maintain and be able to produce evidence of Continuous Professional Development	
6.	**Specialist Roles and Special Conditions**	
	6.1. Single Response Vehicle working 6.1.1. Driver training 6.1.2. Lone working familiarisation 6.2. HART Technicians 6.3. Cycle Response Unit 6.3.1. Additional training in safe cycling skills and lone working. 6.4. Technician Officers/Managers 6.4.1. It is recognised that this group of staff operate predominantly in unmarked lease vehicles, which are not as fully kitted as an SRV. 6.4.2. The scope of practice for these staff is limited by the equipment they have in their vehicles when responding in them. 6.4.3. Officers/managers are required to be familiar with all equipment, drugs and vehicles commensurate to their grade.	

Appendix E: Paramedic

Clinical Practice Areas Grade of Staff: **Paramedic** The Scope of Practice of this Clinical Practice grade also includes the entire scope of practice for *Ambulance Technician.* **Newly Qualified Paramedics (NQP)** – Please refer to section 5.1 in this appendix for NQP condition relating to discharging patients on scene. **Please note.** The extent of the scope of practice for paramedics may exceed the skills and competencies of the individual. Some of the interventions in this appendix may only be practiced by paramedics working in Community Paramedic schemes, and must only be practiced where competency has been assessed as part of a development programme that has been delivered and/or approved by the SECAmb Clinical Education team		**Comments/Notes**
1.	**Responsibility**	
	1.1. **Work in line with the Trust Job Description for the role and adhere to any conditions.** 1.2. Provide emergency response 1.3. Single response (car) 1.4. Crew response (DCA) 1.5. A&E duties 1.6. PTS duties 1.7. Maintain and be able to produce evidence of Continuous Professional Development	
2.	**Skill set**	
	2.1. Adult / Paediatric Intubation	**Supporting document**

	2.2. IV cannulation 2.3. IO Cannulation 2.4. Needle thoracocentesis 2.5. Needle Cricothyroidotomy 2.6. Manual defibrillation 2.7. 12 lead acquisition and diagnosis 2.8. Advanced life support (RCUK/ERC Guidelines) – Adult, Child, Infant, Newborn 2.9. IM injections 2.10. Advanced driving (Blue light) 2.11. Manual Handling 2.12. Auscultation 2.13. Percussion 2.14. External jugular vein cannulation 2.15. Fluid therapy 2.16. Wound assessment and closure (not including local anaesthesia or suturing) 2.17. Supply of courses of certain medicines via Patient Groups Direction (see appendix M) 2.18. Intimate and invasive procedures 2.18.1. Paramedics are permitted to visually examine intimate areas of a patient as part of essential care (such as childbirth). 2.18.2. Paramedics will not carry out any intimate physical and/or internal examinations (rectal or vaginal) 2.18.3. Paramedics may carry out intimate or invasive procedures (such as infiltration of rectal diazepam)	**for section 2.1**1 Minimal Moving & Handling Policy Health & Safety Policy
3.	**Referral rights**	
	3.1. Conveyed patients	

	3.1.1. Unlimited authority to convey to hospital any patient calling 999. 3.1.2. Consideration must be given to advance directives or other care plans relating to preferred place of care 3.1.3. Authorised to convey to appropriate alternative facility (i.e. Minor injury unit) 3.1.4. Authorised to arrange delayed conveyance[10] 3.1.5. Authorised to arrange transport at a higher or lower level of crew (i.e. escalate to CCP or de-escalate to PTS crew) [11] 3.2. Referral and Discharge 3.2.1. Paramedics are encouraged to consider alternative care pathways 3.2.2. For non-conveyed patients the clinician is authorised to: 3.2.2.1. Refer patients back to their own GP 3.2.2.2. Refer patient to Out of Hours provider 3.2.2.3. Refer patient to paramedic practitioner 3.2.2.4. Referral to community teams (either supported by PP or via local pathway arrangements)	

[10] Where procedures or local pathways exist
[11] Where procedures or local pathways exist

	3.3. For non-conveyed patients paramedics are authorised to: 3.3.1. Discharge patients from scene, but must consider seeking support and guidance from another appropriate clinician (same clinical grade or higher). Discharge can be undertaken without support where the patient has a clearly self-limiting condition requiring only simple advice or self-care treatments (i.e. signposting to a pharmacist). 3.3.2. **Instructions for when considering discharging children (12 and under): Please refer to the Discharge procedure** 3.3.3. **Please refer to the guidance given in the Urgent Care Handbook** *(n.b. recent changes to IBIS mean only patients who have fallen or suffered a hypoglycaemic episode should be notified to the IBIS desk for specific referral or notification to be sent to care teams)* 6.5. For all patients who are not conveyed, the following convention must be followed on the PCR/ePCR • Worsening care advice: Specific documented advice relating to anticipated signs or symptoms relating to their condition (i.e. headache, nausea etc.) • Safety netting: Specific documented advice relating to what to do if the patient worsens (i.e. push careline, call back on 999)	

	• Left in care of: Who the patient is being cared for after discharge (if applicable) • Shared decision making: Who was liaised with and document agreed decision	
1.	**Drugs and preparations authorised for use**	
	1.1. JRCALC Drugs[12] 1.1.1. **Please refer to Appendix M** 1.2. PGDs (Trust specific drugs and preparations) 1.2.1. Paracetamol 1.3. Medicine management responsibilities 1.3.1. Paramedics are responsible for the safe keeping of medications in their possession and must report damage, theft or losses. 1.3.2. Use of medicines must be recorded on patient documentation provided. 1.3.3. Paramedics are required to complete Patient Clinical Records legibly. 1.3.4. Paramedics are required to complete any drug audits. 1.3.5. Where a Paramedic is the senior member of a crew, they are responsible for the recording of drug recording.	

[12] JRCALC Drugs are given under a set of specific POM (Prescription Only Medicine) Exemptions, issued by the MHRA.

	1.3.6. Paramedics are responsible for any controlled drugs (CD) in their possession and must sign CDs in and out according to the local arrangements and legal requirements. 1.4. Medicines administration responsibilities 1.4.1. Medicines must only be administered in the dose stated and via the route stated. 1.4.2. Paramedics are authorised to titrate and alter doses up to a maximum stated in guidelines/PGDs 1.4.3. Paramedics must act as the patients advocate and must make any concerns known to others involved in patient care where a potential and/or imminent drug error could occur. 1.4.4. Paramedics must be prepared to be challenged when administering medicines in order to prevent adverse events.	
2.	**Supervision**	
	2.1. Supervises: 2.1.1. Student paramedics 2.1.2. Technicians 2.1.3. ECSWs 2.1.4. Community responders 2.2. First line supervised by: 2.2.1. Clinical Team Leader	
3.	**Documents related to grade**	
	3.1. JRCALC Clinical Practice Guidelines 3.2. HCPC Standards of Proficiency	**Supporting document for section 6.2** HCPC Standards of

		Proficiency
4.	**Pre-requisites for continued employment**	
	4.1. Current HCPC registration 4.2. DBS on appointment 4.3. Occupational health check on appointment 4.4. Full, valid UK driving licence (up to 9 penalty points; will be monitored by line manager) 4.5. Up to date evidence for right to work in the UK. 4.6. Maintain and be able to produce evidence of Continuous Professional Development	
5.	**Specialist Roles and Special Conditions**	
	5.1. **Newly Qualified Paramedics (NQP)** 5.1.1. NQP's should following the following conditions during their agreed period as a Newly Qualified Paramedic. • NQPs must consult another approved Health Care Professional (other than another NQP) prior to discharging a patient on scene, and document any agreements/actions on the PCR/ePCR. • NQPs must consult another approved Health Care Professional (other than another NQP) prior to deviating from national or Trust clinical or operational guidelines, and document any agreements/actions on the PCR/ePCR. o An approved HCP is defined as: a) A Trust clinician, such as PP, CCP, OTL or clinical supervisor. b) A clinician external to SECAmb who has prior knowledge of the patient (i.e. GP or Specialist Nurse), or has specialist clinical knowledge relevant to the support being sought (i.e. understanding of pre/out of hospital care). 5.1.2. 5.2. **Community Paramedic Team working**	

	5.2.1. Paramedics working within Community Paramedic Teams are able to practice with the following competency-based enhancements; • Physical assessment skills • Critical thinking, decision making and professional insight • Mental health risk assessment • Enhanced therapeutic options (i.e. providing a course of oral analgesia under a PGD) • Wound care skills • Understanding of long term health problems, and the management of the co-morbid patient in the acute phase (i.e. suffering exacerbations) • Understanding of healthcare at extremes of age (including importance of hydration and urological health) • Communication skills. (Inter-professional communication, medical terms, making referrals) • Risk assessment and management • Patient advice and communication (health promotion, worsening care advice) • Professional practice (using evidence based medicine, shared decision making, professional leadership, professional and biomedical ethics, providing and receiving supervision, clinical audit, clinical governance) 5.3. Single Response Vehicle working 5.3.1. Driver training 5.3.2. Lone working familiarisation 5.4. HART paramedics 5.5. Gatwick Solo (GATSO) 5.5.1. Additional training given in Airside Driving and lone working. 5.6. Cycle Response Unit	

	5.6.1. Additional training in safe cycling skills and lone working. 5.7. Custody Paramedics 5.8. NHS Pathways Clinical Advisor 5.8.1. Additional training to operate the following systems/software: 5.8.1.1. Computer Aided Dispatch (CAD) 5.8.1.2. ProQa Call taking system 5.8.1.3. EOC Phone systems 5.8.1.4. NHS Pathways 5.8.1.5. Directory of services 5.9. Paramedic Officers/Managers 5.9.1. It is recognised that this group of paramedics operate predominantly in unmarked lease vehicles, which are not as fully kitted as an SRV. 5.9.2. The scope of practice for these staff is limited by the equipment they have in their vehicles when responding in them. 5.9.3. Officers/managers are required to be familiar with all equipment, drugs and vehicles commensurate to their grade.	

Appendix F: Paramedic Practitioner

Clinical Practice Areas Grade of Staff: **Paramedic Practitioner** The Scope of Practice of this Clinical Practice grade also includes the entire scope of practice for *Ambulance Technician* and *Paramedic*		**Comments/Notes**
1.	**Responsibility**	
	1.1. **Work in line with the Trust Job Description for the role and adhere to any conditions.** 1.2. Provide emergency response 1.3. Single response (car) 1.4. Crew response (DCA) 1.5. A&E duties 1.6. PTS duties 1.7. Maintain and be able to produce evidence of Continuous Professional Development	
2.	**Skill set**	
	2.1. Adult / Paediatric Intubation 2.2. IV cannulation 2.3. IO Cannulation 2.4. Needle thoracocentesis 2.5. Needle Cricothyroidotomy 2.6. Manual defibrillation 2.7. 12 lead acquisition and diagnosis 2.8. Advanced life support (RCUK/ERC Guidelines) – Adult, Child, Infant, Newborn 2.9. IM injections	

	2.10. Advanced driving (Blue light) 2.11. Auscultation 2.12. Percussion 2.13. External jugular vein cannulation 2.14. Fluid therapy **2.14.1. Practitioner skills** 2.14.2. Please refer to the Competency & Curriculum Framework (link in the comments column) 2.15. Intimate and invasive procedures 2.15.1. Paramedic practitioners are permitted to visually examine intimate areas of a patient as part of essential care (such as childbirth). 2.15.2. Paramedic practitioners may be required to carry out intimate examinations (inspection and palpation), but are not authorised to carry out internal examinations (rectal or vaginal) 2.15.3. Paramedic practitioners are required to carry out intimate or invasive procedures (such as infiltration of rectal diazepam)	
3.	**Referral rights**	
	3.1. Conveyed patients 3.1.1. Unlimited authority to convey to A&E any patient calling 999. 3.1.2. Consideration must be given to advance directives or other care plans relating to preferred	

	place of care 3.1.3. Authority to convey or arrange conveyance to alternative facility (i.e. Minor Injury Unit, acute or tertiary unit, ambulatory care pathways) 3.1.4. Authorised to arrange delayed conveyance[13] 3.1.5. Authorised to arrange transport at a higher or lower level of crew (i.e. escalate to CCP or de-escalate to PTS crew) [14] 3.2. For non-conveyed patients the clinician is authorised to: 3.2.1. Discharge from care 3.2.2. Refer patients back to their own GP 3.2.3. Refer patient to Out of Hours provider 3.2.4. Refer patient to specialist community care team where approved local pathways exist 3.2.5. Refer patient to any approved secondary or tertiary specialism	

[13] Where procedures or local pathways exist
[14] Where procedures or local pathways exist

	3.3. For non-conveyed patients the clinician is not authorised to: 3.3.1. No restrictions beyond the need to uphold duty of care 6.6. For all patients who are not conveyed, the following convention must be followed on the PCR/ePCR • Worsening care advice: Specific documented advice relating to anticipated signs or symptoms relating to their condition (i.e. headache, nausea etc.) • Safety netting: Specific documented advice relating to what to do if the patient worsens (i.e. push careline, call back on 999) • Left in care of: Who the patient is being cared for after discharge (if applicable) • Shared decision making: Who was liaised with and document agreed decision	
4.	**Drugs and preparations authorised for use**	
	4.1. **JRCALC Drugs[15]** 4.1.1. **Please refer to Appendix M**	

[15] JRCALC Drugs are given under a set of specific POM (Prescription Only Medicine) Exemptions, issued by the MHRA.

	4.2. **PGDs (Trust specific drugs and preparations)** 4.2.1. **Please refer to Appendix M** 4.3. Medicine management responsibilities 4.3.1. Paramedic Practitioners (PP) are responsible for the safe keeping of medications in their possession and must report damage, theft or losses. 4.3.2. Use of medicines must be recorded on patient documentation provided. 4.3.3. PPs are required to complete Patient Clinical Records legibly. 4.3.4. PPs are required to complete any drug audits. 4.3.5. Where a PP is the senior member of a crew, they are responsible for the recording of drug recording. 4.3.6. PPs are responsible for any controlled drugs (CD) in their possession and must sign CDs in and out according to the local arrangements and legal requirements. 4.4. Medicines administration responsibilities 4.4.1. Medicines must only be administered in the dose stated and via the route stated. 4.4.2. PPs are authorised to titrate and alter doses up to a maximum stated in guidelines/PGDs 4.4.3. PPs must act as the patients advocate and must make any concerns known to others involved in patient care where a potential and/or imminent drug error could occur. 4.4.4. PPs must be prepared to be challenged when administering medicines in order to prevent adverse events.	
5.	**Supervision**	
	5.1. Supervises: 5.1.1. Paramedics 5.1.2. Student paramedics	

	5.1.3. Technicians 5.1.4. ECSWs 5.1.5. Community responders 5.2. Supervised by: 5.2.1. GP Trainer 5.2.2. Clinical Team Leader (except in areas related to extended skill-set) 5.2.3. Clinical Operations Manager	
6.	**Documents related to grade**	
	6.1. JRCALC Clinical Practice Guidelines 6.2. HCPC Standards of Proficiency 6.3. SECAmb Paramedic Practitioner Clinical Management Plans 6.4. SECAmb Patient Group Direction documents	
7.	**Pre-requisites for continued employment**	
	7.1. Current HCPC registration 7.2. DBS on appointment 7.3. Occupational health check on appointment 7.4. Full, valid UK driving licence (up to 9 penalty points; will be monitored by line manager) 7.5. Up to date evidence for right to work in the UK. 7.6. Maintain and be able to produce evidence of Continuous Professional Development	
8.	**Specialist Roles and Special Conditions**	
	8.1. Single Response Vehicle working 8.1.1. Driver training	

	8.1.2. Lone working familiarisation 8.2. HART paramedics 8.2.1. PPs are not deployed within HART 8.3. Gatwick Solo (GATSO) 8.4. Custody Paramedics 8.5. Officers/Managers with PP qualification 8.5.1. It is recognised that this group of paramedics operate predominantly in unmarked lease vehicles, which are not as fully kitted as an SRV. 8.5.2. The scope of practice for these staff is limited by the equipment they have in their vehicles when responding in them. 8.5.3. Officers/managers are required to be familiar with all equipment, drugs and vehicles commensurate to their grade.	

Appendix G: Nurse Practitioner

Clinical Practice Areas Grade of Staff: **Nurse Practitioner** The Scope of Practice of this Clinical Practice grade also includes elements of the scope of practice of *Ambulance Technician* but this document details all skills. Do not refer to any other clinical practice area.		**Comments/Notes**
1.	**Responsibility**	
	1.1. **Work in line with the Trust Job Description for the role and adhere to any conditions.** 1.2. Provide emergency response 1.3. Single response (car) 1.4. A&E duties 1.5. Maintain and be able to produce evidence of Continuous Professional Development	
2.	**Skill set**	
	2.1. IV cannulation 2.2. Manual defibrillation 2.3. 12 lead acquisition and diagnosis 2.4. Advanced life support (RCUK/ERC Guidelines) – Adult, Child, Infant, Newborn 2.5. IM injections 2.6. Advanced driving (Blue light) 2.7. Auscultation 2.8. Percussion **2.8.1. Practitioner skills** 2.8.2. Please refer to the Competency & Curriculum Framework (link in the comments column)	

	2.9. Intimate and invasive procedures 2.9.1. Nurse practitioners are permitted to visually examine intimate areas of a patient as part of essential care (such as childbirth). 2.9.2. Nurse practitioners may be required to carry out intimate examinations (inspection and palpation), but are not authorised to carry out internal examinations (rectal or vaginal) 2.9.3. Nurse practitioners may be required to assist paramedics to carry out intimate or invasive procedures (such as infiltration of rectal diazepam)	
3.	**Referral rights**	
	3.1. Conveyed patients 3.1.1. Unlimited authority to convey to A&E any patient calling 999. 3.1.2. Consideration must be given to advance directives or other care plans relating to preferred place of care 3.1.3. Authority to convey or arrange conveyance to alternative facility (i.e. Minor Injury Unit, acute or tertiary unit, ambulatory care pathways) 3.1.4. Authorised to arrange delayed conveyance[16] 3.1.5. Authorised to arrange transport at a higher or lower level of crew (i.e. escalate to paramedic	

[16] Where procedures or local pathways exist

	or de-escalate to PTS crew) [17] 3.2. For non-conveyed patients the clinician is authorised to: 3.2.1. Discharge from care 3.2.2. Refer patients back to their own GP 3.2.3. Refer patient to Out of Hours provider 3.2.4. Refer patient to specialist community care team 3.2.5. Refer patient to specialist community care team where approved local pathways exist 3.3. For non-conveyed patients the clinician is not authorised to: 3.3.1. No restrictions beyond the need to uphold duty of care 3.4. For all patients who are not conveyed, the following convention must be followed on the PCR/ePCR • Worsening care advice: Specific documented advice relating to anticipated signs or symptoms relating to their condition (i.e. headache, nausea etc.) • Safety netting: Specific documented advice relating to what to do if the patient worsens (i.e. push careline, call back on 999)	

[17] Where procedures or local pathways exist

	• Left in care of: Who the patient is being cared for after discharge (if applicable) • Shared decision making: Who was liaised with and document agreed decision	
4.	**Drugs and preparations authorised for use**	
	4.1. **JRCALC Drugs[18]** 4.1.1. Nurse Practitioners cannot administer any drug under JRCALC POM exemption. Some drugs are available to NPs under PGD – see section 4.2 4.2. **PGDs (Trust specific drugs and preparations)** **4.2.1. PGDs, which are also JRCALC drugs** 4.2.2. **Please refer to Appendix M** **4.2.3. Practitioner specific PGDs** 4.2.4. **Please refer to Appendix M** 4.3. Medicine management responsibilities	

[18] JRCALC Drugs are given under a set of specific POM (Prescription Only Medicine) Exemptions, issued by the MHRA.

	4.3.1. Nurse Practitioners (NP) are responsible for the safe keeping of medications in their possession and must report damage, theft or losses. 4.3.2. Use of medicines must be recorded on patient documentation provided. 4.3.3. NPs are required to complete Patient Clinical Records legibly. 4.3.4. NPs are required to complete any drug audits. 4.3.5. Where a NP is the senior clinician on scene, they are responsible for the recording of drug recording. 4.4. Medicines administration responsibilities 4.4.1. Medicines must only be administered in the dose stated and via the route stated. 4.4.2. NPs are authorised to titrate and alter doses up to a maximum stated in guidelines/PGDs 4.4.3. NPs must act as the patients advocate and must make any concerns known to others involved in patient care where a potential and/or imminent drug error could occur. 4.4.4. NPs must be prepared to be challenged when administering medicines in order to prevent adverse events.	
5.	**Supervision**	
	5.1. Supervises: **5.1.1. Nurse Practitioners cannot provide Paramedic level supervision to other grades of staff.** 5.1.2. Student paramedics 5.1.3. Technicians 5.1.4. ECSWs 5.1.5. Community responders	

	5.2. Supervised by: 5.2.1. GP Trainer 5.2.2. Clinical Team Leader (clinically and operationally)	
6.	**Documents related to grade**	**NMC: The Code:** http://www.nmc-uk.org/Nurses-and-midwives/The-code/The-code-in-full/
	6.1. JRCALC Clinical Practice Guidelines 6.2. Nursing & Midwifery Council - The code: Standards of conduct, performance and ethics for nurses and midwives 6.3. SECAmb Paramedic Practitioner Clinical Management Plans 6.4. SECAmb Patient Group Direction documents	
7.	**Pre-requisites for continued employment**	
	7.1. Current NMC registration 7.2. DBS on appointment 7.3. Occupational health check on appointment 7.4. Full, valid UK driving licence (up to 9 penalty points; will be monitored by line manager) 7.5. Up to date evidence for right to work in the UK. 7.6. Maintain and be able to produce evidence of Continuous Professional Development	
8.	**Specialist Roles and Special Conditions**	
	8.1. Single Response Vehicle working 8.1.1. Driver training 8.1.2. Lone working familiarisation	

Appendix H: Critical Care Paramedic

Clinical Practice Areas Grade of Staff: **Critical Care Paramedic** The Scope of Practice of this Clinical Practice grade also includes the entire scope of practice for *Ambulance Technician* and *Paramedic* n.b. This appendix also includes CCPs in the Critical Care Paramedic Practice Lead (CCPPL) role. The clinical skills and scope of practice are the same, but the CCPPL has other responsibilities, and this appendix states the supervision arrangements relating to these CCPs.		**Comments/Notes**
1.	**Responsibility**	
	1.1. **Work in line with the Trust Job Description for the role and adhere to any conditions.** 1.2. Provide emergency response 1.3. Single response (car) 1.4. Crew response (DCA) 1.5. A&E duties 1.6. PTS duties 1.7. Maintain and be able to produce evidence of Continuous Professional Development	**Supporting document for section 1.1** Critical Care Paramedic Job Description
2.	**Skill set**	
	2.1. Adult / Paediatric Intubation 2.2. IV cannulation 2.3. Needle thoracocentesis 2.4. Needle Cricothyroidotomy 2.5. Manual defibrillation 2.6. 12 lead acquisition and diagnosis	

	2.7. Advanced life support (RCUK/ERC Guidelines) – Adult, Child, Infant, Newborn 2.8. IM injections 2.9. Advanced driving (Blue light) 2.10. Auscultation 2.11. Percussion 2.12. External jugular vein cannulation 2.13. Fluid therapy 2.14. Tibial insertion of Intraosseous Needle 2.15. Humeral Head insertion of Intraosseous Needle 2.16. Insertion of Oro-gastric tube for gastric decompression. 2.17. Intimate and invasive procedures 2.17.1. Critical Care Paramedics are permitted to visually examine intimate areas of a patient as part of essential care (such as childbirth). 2.17.2. Critical Care Paramedics may be required to carry out intimate examinations (inspection and palpation), but are not authorised to carry out internal examinations (rectal or vaginal) 2.17.3. Critical Care Paramedics are required to carry out intimate or invasive procedures (such as infiltration of rectal diazepam) 2.18. Syringe driver operation 2.19. Volumetric pump operation 2.20. Pacing under sedation 2.21. Synchronised Cardioversion under sedation 2.22. Open surgical airway 2.23. Simple Thoracotomy 2.24. 2nd line asthma therapy 2.25. 2nd line Seizure therapy 2.26. Ultrasound	

	2.27. Vascular access using ultrasound. 2.28. Mechanical CPR 2.29. Inotropic support 2.30. Procedural Sedation 2.31. ROSC sedation 2.32. Paralysis	
3.	**Referral rights**	
	3.1. Conveyed patients 3.1.1. Unlimited authority to convey to hospital any patient calling 999. 3.1.2. Consideration must be given to advance directives or other care plans relating to preferred place of care 3.1.3. Convey patients to Regional Trauma Centre 3.1.4. Convey patients to a DGH following advanced assessment & triage, instead of Regional Trauma centre 3.1.5. Authority to convey or arrange conveyance to alternative facility (i.e. Minor Injury Unit, acute	

	or tertiary unit, ambulatory care pathways) 3.1.6. Authorised to arrange delayed conveyance[19] 3.1.7. Authorised to arrange transport at lower level of crew (i.e. de-escalate to PTS crew) [20] 3.2. For non-conveyed patients the clinician is authorised to: 3.2.1. Discharge from care 3.2.2. Refer patients back to their own GP 3.2.3. Refer patient to Out of Hours provider 3.2.4. Refer patient to paramedic practitioner 3.2.5. Refer patient to specialist community care team where approved local pathways exist 3.2.6. Refer patient to any approved secondary or tertiary specialism 3.3. For non-conveyed patients the clinician is not authorised to: 3.3.1. No restrictions beyond the need to uphold duty of care 8.2. For all patients who are not conveyed, the following convention must be followed on the	

[19] Where procedures or local pathways exist
[20] Where procedures or local pathways exist

	PCR/ePCR • Worsening care advice: Specific documented advice relating to anticipated signs or symptoms relating to their condition (i.e. headache, nausea etc.) • Safety netting: Specific documented advice relating to what to do if the patient worsens (i.e. push careline, call back on 999) • Left in care of: Who the patient is being cared for after discharge (if applicable) Shared decision making: Who was liaised with and document agreed decision	
4.	**Drugs and preparations authorised for use**	
	4.1. JRCALC Drugs[21] 4.1.1. **Please refer to Appendix M** 4.2. PGDs (Trust specific drugs and preparations) 4.2.1. **Please refer to Appendix M** 4.3. Medicine management responsibilities 4.3.1. Critical Care Paramedics (CCP) are responsible for the safe keeping of medications in their possession and must report damage, theft or losses.	

[21] JRCALC Drugs are given under a set of specific POM (Prescription Only Medicine) Exemptions, issued by the MHRA.

	4.3.2. Use of medicines must be recorded on patient documentation provided. 4.3.3. CCPs are required to complete Patient Clinical Records legibly. 4.3.4. CCPs are required to complete any drug audits. 4.3.5. Where a CCP is the senior member of a crew, they are responsible for the recording of drug recording. 4.3.6. CCPs are responsible for any controlled drugs (CD) in their possession and must sign CDs in and out according to the local arrangements and legal requirements. 4.4. Medicines administration responsibilities 4.4.1. Medicines must only be administered in the dose stated and via the route stated. 4.4.2. CCPs are authorised to titrate and alter doses up to a maximum stated in guidelines/PGDs 4.4.3. CCPs must act as the patients advocate and must make any concerns known to others involved in patient care where a potential and/or imminent drug error could occur. 4.4.4. CCPs must be prepared to be challenged when administering medicines in order to prevent adverse events.	
5.	**Supervision**	
	5.1. Supervises as a Senior/Specialist Paramedic: 5.1.1. Critical Care Paramedics (CCPPLs only) 5.1.2. Qualified Paramedics 5.1.3. Student paramedics 5.1.4. Technicians 5.1.5. ECSWs 5.1.6. Community responders	

	5.2. Supervised by: 5.2.1. Critical Care Paramedic Practice Lead (CCPPL) 5.2.2. Critical Care Unit Mentor (Acute Trust based) 5.2.3. Clinical Team Leader (except in areas related to extended skill-set) 5.2.4. Clinical Operations Manager	
6.	**Documents related to grade**	
	6.1. JRCALC Clinical Practice Guidelines 6.2. HCPC Standards of Proficiency 6.3. Critical Care Paramedic Competency and Curriculum Framework 6.4. SECAmb Patient Group Direction documents	
7.	**Pre-requisites for continued employment**	
	7.1. Current HCPC registration 7.2. DBS on appointment 7.3. Occupational health check on appointment 7.4. Full, valid UK driving licence (up to 9 penalty points; will be monitored by line manager) 7.5. Up to date evidence for right to work in the UK. 7.6. Maintain and be able to produce evidence of Continuous Professional Development	
8.	**Specialist Roles and Special Conditions**	
	8.1. Tactical Firearms Team deployment 8.1.1. For details of training relating to firearms, refer to the **Firearms Tactical Procedure for Critical Care Paramedics** (this is a restricted document) 8.2. Single Response Vehicle working 8.2.1. Driver training 8.2.2. Lone working familiarisation 8.3. HART paramedics 8.3.1. CCPs are not deployed in HART teams	

	8.4. Gatwick Solo (GATSO) 8.4.1. CCPs are not deployed as Gatwick Solo responders. 8.5. Cycle Response Unit 8.5.1. CCPs are not deployed as Cycle Responders 8.6. Custody Paramedics 8.6.1. CCPs are not deployed as Custody Paramedics 8.7. Officers/Managers with CCP qualification 8.7.1. It is recognised that this group of paramedics operate predominantly in unmarked lease vehicles, which are not as fully kitted as an SRV. 8.7.2. The scope of practice for these staff is limited by the equipment they have in their vehicles when responding in them. 8.7.3. Officers/managers are required to be familiar with all equipment, drugs and vehicles commensurate to their grade.	

Appendix I: Clinical Advisor/Clinical Supervisor

Clinical Practice Areas Grade of Staff: **Paramedic (minimum) or Registered Nurse** Due to the combined nature of this appendix (paramedic and nurse), elements of the paramedic scope of practice appendix must be considered. For nurse clinical advisors, their primary registration provides evidence of basic level of competency.		**Comments/Notes**
1.	**Responsibility**	
	1.1. Receive Primary Emergency Calls from Members of the public and process appropriately. 1.2. Continue Emergency Calls from Emergency Call Operators where necessary and provide extended care advice utilising own clinical knowledge and the pathways system. 1.3. Provide Symptom Management Advice directly from the Pathways system, or in accordance with NICE Guidelines, Toxbase, or any other nationally accredited source. 1.4. Provide information to crews relating to the treatment options available to them for their patients using nationally recognised sources. 1.5. Provide advice regarding the appropriateness of non-conveyance to non-registered health professionals using own clinical knowledge and/or pathways system.	
2.	**Skill set**	
	2.1. Qualified in the use of NHS Pathways 2.2. Qualified Paramedic or Nurse. 2.2.1. Please refer to paramedic appendix for operational skill set 2.2.2. NHSP Nurse Clinical Advisors do not respond from the EOC and therefore do not have an operational scope of practice	
3.	**Referral rights**	

	3.1. Authorised to refer any patient to another health care practitioner or health service as advised by the Pathways Software, or local guidance. 3.2. Consideration must be given to preferences stated in any advance care plan available via IBIS or other system 3.3. Authorised to arrange suitable transport for patients to any receiving facility. 3.4. Authorised to arrange any category of Urgent Journey 3.5. Authorised to Discharge patients where this is in line with the advice given by the pathways software. 8.3. For all patients who are not conveyed, the following convention must be followed on the PCR/ePCR/CAD • Worsening care advice: Specific documented advice relating to anticipated signs or symptoms relating to their condition (i.e. headache, nausea etc.) • Safety netting: Specific documented advice relating to what to do if the patient worsens (i.e. push careline, call back on 999) • Left in care of: Who the patient is being cared for after discharge (if applicable) Shared decision making: Who was liaised with and document agreed decision	
4.	**Drugs and preparations authorised for use**	
	4.1. Not applicable in the control room function. Please refer to specific clinical grade for reference	
5.	**Supervision**	
	5.1. Supervises: 5.1.1. ECOs and Clinical Supervisors in Training. 5.1.2. Remotely supervises clinical grades junior to the grade of Paramedic, providing patient care advice. 5.2. Supervised by:	

	5.2.1. Duty Dispatch Manager (Conduct Only) 5.2.2. Senior Clinical Supervisors	
6.	**Documents related to grade**	
	6.1. JRCALC Clinical Practice Guidelines 6.2. HCPC Standards of Proficiency 6.3. NHSP competency/curriculum/training documents	**Supporting document for section 6.2** HCPC Standards of Proficiency
7.	**Pre-requisites for continued employment**	
	7.1. Current HCPC or NMC registration (as appropriate) 7.2. DBS on appointment 7.3. Occupational health check on appointment 7.4. Full, valid UK driving licence (up to 9 penalty points; will be monitored by line manager) 7.5. Up to date evidence for right to work in the UK. 7.6. Maintain and be able to produce evidence of Continuous Professional Development 7.7. Control licence audits to prescribed levels	
8.	**Specialist Roles and Special Conditions**	
	8.1.1. See Paramedic appendix	

Appendix J: Registered Nurse

Clinical Practice Areas Grade of Staff: **Nurse (Response Capable)** The Scope of Practice of this Clinical Practice grade also includes elements of the scope of practice of *Ambulance Technician* but this document details all skills. Do not refer to any other clinical practice area. Nurses within the Trust who provide a response capability may not have specific ambulance skills or qualifications and therefore cannot crew emergency ambulances. This scope of practice exists to ensure that managers with a nursing qualification can provide a first response where appropriate to support operations.		**Comments/Notes**
1.	**Responsibility**	
	1.1. **Work in line with the Trust Job Description for the role and adhere to any conditions.** 1.1.1. Provide emergency response 1.1.2. Single response (car) 1.1.3. A&E duties 1.1.4. Maintain and be able to produce evidence of Continuous Professional Development	
2.	**Skill set**	
	2.1. IV cannulation 2.2. IO cannulation (Tibial Tuberosity) 2.3. Manual defibrillation 2.4. 12 lead acquisition and diagnosis 2.5. Advanced life support (RCUK/ERC Guidelines) – Adult, Child, Infant, Newborn 2.6. IM injections 2.7. Advanced driving (Blue light) 2.8. Auscultation 2.9. Percussion	

3.	**Referral rights**	
	3.1. Conveyed patients 3.1.1. Unlimited authority to request conveyance to A+E of any patient calling 999 3.1.2. Consideration must be given to advance directives or other care plans relating to preferred place of care 3.1.3. Authority to convey or arrange conveyance to alternative facility (i.e. Minor Injury Unit, acute or tertiary unit, ambulatory care pathways) 3.2. Non Conveyance 3.2.1. Technicians and Advanced Technicians are encouraged to consider alternative care pathways 3.2.2. For non-conveyed patients the clinician is authorised to: 3.2.2.1. Refer patients back to their own GP 3.2.2.2. Refer patient to Out of Hours provider 3.2.2.3. Refer patient to paramedic practitioner 3.2.2.4. Referral to community teams (either supported by PP or via local pathway	

	arrangements) 3.3. For non-conveyed patients the clinician is not authorised to: 3.3.1. Discharge patients from scene without arranging following up or, where practicable, seeking assistance/advice[22] 8.4. For all patients who are not conveyed, the following convention must be followed on the PCR/ePCR • Worsening care advice: Specific documented advice relating to anticipated signs or symptoms relating to their condition (i.e. headache, nausea etc.) • Safety netting: Specific documented advice relating to what to do if the patient worsens (i.e. push careline, call back on 999) • Left in care of: Who the patient is being cared for after discharge (if applicable) Shared decision making: Who was liaised with and document agreed decision	
4.	**Drugs and preparations authorised for use**	
	4.1. **JRCALC Drugs[23]**	

[22] Unless the patient refuses care plan against the wishes of the crew, and has mental capacity.

	4.1.1. Nurse Practitioners can only administer drugs under a relevant PGD or by specific exemption in the Human Medicines Regulations (2012) – ALS providers and Schedule 19). 4.1.2. **Please refer to Appendix M** 4.2. **PGDs (Trust specific drugs and preparations)** **4.2.1. PGDs, which are also JRCALC drugs** 4.2.2. **Please refer to Appendix M** 4.3. Medicine management responsibilities 4.3.1. Nurses are responsible for the safe keeping of medications in their possession and must report damage, theft or losses. 4.3.2. Use of medicines must be recorded on patient documentation provided. 4.3.3. Nurses are required to complete Patient Clinical Records legibly. 4.3.4. Nurses are required to complete any drug audits. 4.3.5. Where a Nurse is the senior clinician on scene, they are responsible for the	

[23] JRCALC Drugs are given under a set of specific POM (Prescription Only Medicine) Exemptions, issued by the MHRA.

	recording of drug recording. 4.4. Medicines administration responsibilities 4.4.1. Medicines must only be administered in the dose stated and via the route stated. 4.4.2. Nurses are authorised to titrate and alter doses up to a maximum stated in guidelines/PGDs 4.4.3. Nurses must act as the patients advocate and must make any concerns known to others involved in patient care where a potential and/or imminent drug error could occur. 4.4.4. Nurses must be prepared to be challenged when administering medicines in order to prevent adverse events.	
5.	**Supervision**	
	5.1. Supervises: **5.1.1. Nurses cannot provide Paramedic level supervision to other grades of staff.** 5.1.2. Student paramedics 5.1.3. Technicians 5.1.4. ECSWs 5.1.5. Community responders 5.1.6. Suitable to grade of employment/experience and qualification may be deployed in a Supervisor/ Bronze/Tactical role 5.2. Supervised by: 5.2.1. Paramedic 5.2.2. PP/CCP 5.2.3. Nurse Practitioner	

6.	**Documents related to grade**	**NMC: The Code:** http://www.nmc-uk.org/Nurses-and-midwives/The-code/The-code-in-full/
	6.1. JRCALC Clinical Practice Guidelines 6.2. Nursing & Midwifery Council - The code: Standards of conduct, performance and ethics for nurses and midwives 6.3. SECAmb Patient Group Direction documents	
7.	**Pre-requisites for continued employment**	
	7.1. Current NMC registration 7.2. DBS on appointment 7.3. Occupational health check on appointment 7.4. Full, valid UK driving licence (up to 9 penalty points; will be monitored by line manager) 7.5. Up to date evidence for right to work in the UK. 7.6. Maintain and be able to produce evidence of Continuous Professional Development	
8.	**Specialist Roles and Special Conditions**	
	8.1. Single Response Vehicle working 8.1.1. Driver training 8.1.2. Lone working familiarisation,	

Appendix K: Doctors

Doctors employed directly by the Trust who have an involvement in patient care, should work within their scope of practice as defined by their specialist training.

Appendix L: 111 Clinical Advisor/ 111 Senior Clinical Advisor

	Clinical Practice Areas Grade of Staff: **Paramedic (minimum) or Registered Nurse** Due to the combined nature of this appendix (paramedic and nurse), elements of the paramedic scope of practice appendix must be considered. For nurse clinical advisors, their primary registration provides evidence of basic level of competency.	
1.	**Responsibility**	
	1.1. Receive Primary Urgent and Emergency Calls from Members of the public and process appropriately. 1.2. Continue Urgent Calls from Health Advisors where necessary and provide extended care advice utilising own clinical knowledge and the pathways system. 1.3. Provide Symptom Management Advice directly from the Pathways system, or in accordance with NICE Guidelines, Toxbase, or any other nationally accredited source. 1.4. Provide information to other Health Care Professionals relating to the treatment options available to them for their patients using nationally recognised sources and Professional Support Line procedures. 1.5. To provide health information and medication advice to the public in line with approved	

	sources in the Health Information LOP	
2.	**Skill set**	
	2.1. Qualified in the use of NHS Pathways, Adastra and Directory of Services 2.2. Qualified Paramedic or Nurse.	
3.	**Referral rights**	
	3.1. Authorised to refer any patient to another health care practitioner or health service as advised by the Pathways Software, or local guidance. 3.2. Authorised to arrange suitable transport for patients to any receiving facility. 3.3. Authorised to arrange any category of Urgent Journey 3.4. Authorised to Discharge patients where this is in line with the advice given by the pathways software. 8.5. For all patients who are not conveyed, the following convention must be followed on the PCR/ePCR • Worsening care advice: Specific documented advice relating to anticipated signs or symptoms relating to their condition (i.e. headache, nausea etc.) • Safety netting: Specific documented advice relating to what to do if the patient worsens (i.e. push careline, call back on 999) • Left in care of: Who the patient is being cared for after discharge (if applicable) Shared decision making: Who was liaised with and document agreed decision	
4.	**Drugs and preparations authorised for use**	
	4.1. Not applicable in the control room function. Please refer to specific clinical grade for reference	
5.	**Supervision**	

	5.1. Supervises: 5.1.1. 111 Health Advisors ~~ECOs and Clinical Supervisors in Training~~. 5.2. Supervised by: 5.2.1. Contact Centre Supervisors (Conduct Only) 5.2.2. 111 Senior Clinical Advisors	
6.	**Documents related to grade**	
	6.1. JRCALC Clinical Practice Guidelines 6.2. HCPC Standards of Proficiency or NMC Code of Conduct 6.3. NHSP competency/curriculum/training documents	
7.	**Pre-requisites for continued employment**	
	7.1. Current HCPC or NMC registration (as appropriate) and evidence of on-going registration subsequent to appointment. 7.2. DBS on appointment, and if required subsequent to appointment 7.3. Occupational health check on appointment 7.4. Up to date evidence for right to work in the UK. 7.5. Maintain and be able to produce evidence of Continuous Professional Development 7.6. Control licence audits to prescribed levels	
8.	**Specialist Roles and Special Conditions**	
	8.1. See Paramedic appendix	

Appendix M: Medicines Administration Authorised for use, by Clinical Grade

Key:

- **PGD:** Patient Group Direction
- **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)

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	**Dose**	**Route(s)**	**Mechanism**	**Type of Use (administration, supply, both)**	**CFR / IECR**	**Emergency Care Support Worker**	**Associate Practitioner**	**Technician/ Advanced Technician**	**Paramedic (inc' NQP)**	**Paramedic Practitioner**	**Critical Care Paramedic**	**Nurse/ Nurse Practitioner**
Activated Charcoal	1 x bottle	Oral	PGD	Administration					Yes	Yes	Yes	Yes
Adrenaline 1:10,000	1mg/10ml	IV/IO	S17 / ALS	Administration					Yes	Yes	Yes	Yes
Adrenaline 1:1000	500mcg	IM	S19	Administration			**IM Only**	**IM Only**	Yes	Yes	Yes	Yes
Amiodarone (pre-filled)	300mg	IV/IO	S17 / ALS	Administration					Yes	Yes	Yes	Yes
Amoxicillin	500mg	PO	PGD	Supply						Yes		
Aspirin	300mg	PO	TA	Administration	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Atropine 600mcg	600mcg	IV/IO	S19	Administration					Yes	Yes	Yes	Yes
Benzylpenicillin	600mg	IV/IO	S17	Administration					Yes	Yes	Yes	Yes
Calcium Chloride	10%/10ml	IV/IO	PGD	Administration							Yes	

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	Dose	Route(s)	Mechanism	Type of Use (administration, supply, both)	CFR / IECR	Emergency Care Support Worker	Associate Practitioner	Technician/ Advanced Technician	Paramedic (inc' NQP)	Paramedic Practitioner	Critical Care Paramedic	Nurse/ Nurse Practitioner
Chlorphenamine	10mg/1ml	IV/IO (IV preferred) IM	S19	Administration			**IM Only**	**IM Only**	Yes	Yes	Yes	Yes
Clarithromycin	125mg suspension	PO	PGD	Supply						Yes		
Clarithromycin	250mg tablet	PO	PGD	Supply						Yes		
Clopidogrel	75mg	PO	TA	Administration			Yes	Yes	Yes	Yes	Yes	Yes
Co-Amoxiclav	625mg	PO	PGD	Supply						Yes		
Co-Amoxiclav	1.2g	IV	PGD	Administration							Yes	
Diazemuls IV	10mg/2ml	IV/IO	S17	Administration					Yes	Yes	Yes	Yes
Diazepam	2.5mg	PR	TA	Administration					Yes	Yes	Yes	Yes
Diazepam	5mg	PR	TA	Administration					Yes	Yes	Yes	Yes
Entonox	NA	Inhaled	TA	Administration		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Flumazenil	100 mcg	IV/IO	PGD	Administration							Yes	
Furosemide	20mg/2ml	IV	S17	Administration					Yes	Yes	Yes	Yes
Glucagon	1mg	IM/SC	S19	Administration			Yes	Yes	Yes	Yes	Yes	Yes
Glucogel	40%/23g	Buccal	TA	Administration		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Glucose 10%	500ml	IV	S17	Administration					Yes	Yes	Yes	Yes
GTN	400mcg	Sub lingual	TA	Administration			Yes	Yes	Yes	Yes	Yes	Yes
Heparin	5000 IU	IV	S17	Administration					Yes	Yes	Yes	Yes

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	Dose	Route(s)	Mechanism	Type of Use (administration, supply, both)	CFR / IECR	Emergency Care Support Worker	Associate Practitioner	Technician/ Advanced Technician	Paramedic (inc' NQP)	Paramedic Practitioner	Critical Care Paramedic	Nurse/ Nurse Practitioner
Hydrocortisone	100mg	IV (preferred) IO/IM	S19	Administration			**IM Only**	**IM Only**	Yes	Yes	Yes	Yes
Ibuprofen Suspension	100mg/5ml	PO	PGD	Supply						Yes		
Ibuprofen Sachet	100mg/5ml	PO	TA	Administration			Yes	Yes	Yes	Yes	Yes	Yes
Ibuprofen Tablet	200mg	PO	PGD	Supply						Yes		
Ibuprofen Tablet	200mg	PO	TA	Administration			Yes	Yes	Yes	Yes	Yes	Yes
Ipratropium Bromide	250mcg	Nebulised	TA	Administration			Yes	Yes	Yes	Yes	Yes	Yes
Ketamine	10mg/1ml	IV/IO	PGD	Administration							Yes	
Lidocaine (Lignocaine)	1%	SC	PGD	Administration						Yes		
Magnesium Sulphate	2g or 4g (depending on PGD)	IV/IO	PGD	Administration							Yes	
Magnesium Sulphate	150mg	Nebulised	PGD	Administration							Yes	
Midazolam	5mg/5ml	IV/IO	PGD	Administration							Yes	
Morphine Sulphate	10mg/1ml	IV/IO	S17 (PGD**)	Administration					Yes	Yes	Yes	Yes**
Naloxone Hydrochloride	400mcg/1ml	IV/IO/IM/IN	S19	Administration			**IM Only**	**IM Only**	Yes	Yes	Yes	Yes
Naproxen	250mg	PO	PGD	Supply						Yes		
Nitrofurantoin	50mg	PO	PGD	Supply						Yes		
Ondansetron	2mg	IV	S17	Administration					Yes	Yes	Yes	Yes

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	Dose	Route(s)	Mechanism	Type of Use (administration, supply, both)	CFR / IECR	Emergency Care Support Worker	Associate Practitioner	Technician/ Advanced Technician	Paramedic (inc' NQP)	Paramedic Practitioner	Critical Care Paramedic	Nurse/ Nurse Practitioner
Oxygen	NA	Inhaled	TA	Administration	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oral Rehydration Salts	Sachet	PO	TA	Supply						Yes		
Paracetamol	10mg/1ml	IV	S17	Administration					Yes	Yes	Yes	Yes
Paracetamol	120mg/5ml suspension	PO	PGD	Supply						Yes		
Paracetamol	250mg/5ml suspension	PO	PGD	Supply						Yes		
Paracetamol	250mg (Fastmelt/ oro-dispersible)	PO	PGD	Supply						Yes		
Paracetamol	500mg	PO	PGD	Supply						Yes		
Paracetamol	500mg	PO	TA	Administration			Yes	Yes	Yes	Yes	Yes	Yes
Paracetamol	120mg/5ml sachet (Calpol)	PO	TA	Administration			Yes	Yes	Yes	Yes	Yes	Yes
Penicillin V	250mg	PO	PGD	Supply						Yes		
Phenytoin	250mg/5ml	IV/IO	PGD	Administration							Yes	
Prednisolone	5mg	PO	PGD	Supply						Yes		
Prednisolone	1mg/1ml	PO	PGD	Administration					Yes	Yes	Yes	Yes
Prednisolone	1mg/1ml	PO	PGD	Supply						Yes		
Rocuronium	10mg/1ml	IV/IO	PGD	Administration							Yes	
Salbutamol	2.5mg	Nebulised	TA	Administration	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Name of Medicine (Controlled Drugs highlighted in RED Restricted medicines highlighted AMBER)	Dose	Route(s)	Mechanism	Type of Use (administration, supply, both)	CFR / IECR	Emergency Care Support Worker	Associate Practitioner	Technician/ Advanced Technician	Paramedic (inc' NQP)	Paramedic Practitioner	Critical Care Paramedic	Nurse/ Nurse Practitioner
Salbutamol	5mg	Nebulised	TA	Administration	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sodium Chloride Ampoule	0.9% 10ml	IV/IO	S17	Administration					Yes	Yes	Yes	Yes
Sodium Chloride	0.9% 150ml	IV/IO	S17	Administration							Yes	
Sodium Chloride	0.9% 500ml	IV/IO	S17	Administration					Yes	Yes	Yes	Yes
Sodium Chloride (hypertonic)	5% 500ml	IV/IO	PGD	Administration							Yes	
Tenecteplase	10,000 units	IV	S17	Administration					Yes	Yes	Yes	
Ticagrelor	90mg	PO	PGD	Administration					Yes	Yes	Yes	Yes
Tranexamic Acid	100mg	IV	PGD	Administration					Yes	Yes	Yes	Yes
Trimethoprim	200mg	PO	PGD	Supply						Yes		
Water for Injection	NA	IV/IO	Diluent	Administration					Yes	Yes	Yes	Yes

*Associate practitioners are required to undertake the first five administrations of those drugs marked under supervision prior to moving to autonomous practice. Supervision will usually be remote through accessing a paramedic on the Clinical Desk or PP Desk.

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

Document Control

Manager Responsible

Name:	Andy Collen
Job Title:	Consultant Paramedic/Head of Clinical Development
Directorate:	Clinical Operations

Committee/Working Group to approve	Senior Management Team	
Version No. V9.03	FINAL	Date:

Draft/Evaluation/Approval (Insert stage of process)

Person/Committee	Comments	Version	Date
Andy Collen	Minor correction to Appendix M regarding medicines mechanism for each stated medicine	V9.09	17th Oct 2017
Andy Collen	Final changes for JPF/SMT (clean version)	V9.05	Sept 17
Andy Collen	Amendments from consultation	V9.04	Sept 17
Andy Collen	Major update to Appendix M Minor updates to body of policy document, including statement regarding formulary	V9.03	Sept 17
Andy Collen	Updated error in Appendix M – added Prochlorperazine	V9.00	Feb 17
Andy Collen	Updates to PTS appendix and review of current version with Asst Company Secretary for publication	V8.01	Jan 17
Andy Collen	Update to Technician appendix to clarify position on ability to use skills from all lower grades	V8.00c	10/10/16
Andy Collen	Changes to clarify discharge arrangements in line with Discharge Procedure. Changes to CCP appendix clarifying supervisory arrangements for CCPPLs	V8.00b	25/4/16
Andy Collen	Further minor clarity relating to discharge of children	V7.00	14/4/16
Andy Collen/CQWG	Minor changes to wording to clarify discharge authority by Technicians CCPs appendix update	V7.00a	18/2/16
Andy Collen	CQWG – changes to paramedic appendix	V6.00	27/10/15

	approved Associate Practitioner use of Adrenaline 1:100 reverted to supported decision model		
Andy Collen	Minor changes to paramedic appendix to support the CPT project	V6.00	15/10/15
Andy Collen	Final version sent for publication	V6.00	
Andy Collen	Updated with KLOE's	V6.00	12/9/15
CQWG	Approval of minor changes to Paramedic appendix to support Community Paramedic programme	V6.00	21/08/2015
CQWG	Approval of changes to appendices	V6.00 (amended)	15/06/2015
Andy Collen	Clarification regarding supervised administration of medicines (ECSW appendix)	V6.00 App 01	27/05/2015
RMCGC	For approval of policy	V6.00	16/03/2015
Andy Collen	Appendix M updated from Medicines Management Lead. Final draft for RMCGC Trainee Paramedic title to Associate Practitioner	V5.06	25/02/2015
Andy Collen	Minor changes required from CQWG.	V5.05	12/02/2015
Clinical Quality Working Group	Recommended for approval at RMCGC	V5.03	3/02/2015
Andy Collen	Change of role title: Trainee Paramedic now Associate Practitioner	V5.03	26/01/2015
Andy Collen	Additional guidance relating to ECSWs and undergrad student paramedics	V5.02	24/12/2014
Andy Collen	Draft version agreed as operational draft – approved by Andy Newton. Agenda item requested at Dec CQWG. Requires ratification at RMCGC	V5.01	19/11/2014
Andy Collen	Inclusion of changes from comments from L&D	V5.00	19/11/2014
Andy Collen	Change AECSW to Trainee Paramedic. Additional information regarding protection of paramedic title	V5.00	18/11/2014

Andy Collen	Development of Advanced ECSW appendix	V5.00	11/11/2014
Dave Wells/Andy Collen	Development of new appendix for Fire Service IECR provision	V5.00	22/07/2014
CQWG	Updates approved to ECSW and Technician appendices	V5.00	
Andy Collen	Changes to Equality Analysis	V5.00	20/11/2013
CQWG	Revision to Appendix M (medicines)	V5.00	12/08/2013
Risk Management and Clinical Governance Committee	Approved	V5.00	04/07/2013
Equality Analysis Engagement and Action Plan	Minor changes to EA statements	V4.04	26/06/2013
Clinical Quality Working Group	For ratification	V4.04	07/06/2013
Medicine Management Sub-Group	For approval of Appendix M	V4.04	20/05/2013
Andy Collen	Updates following comments from SCOT and Medical	V4.04	16/05/2013
SCOT	For information/comment	V4.03	16/05/2013
Andy Collen	Collation of changes	V4.03	15/05/2013
Andy Parker	Additional of Medicines Management Appendix	V4.02	14/05/2013
SCOT	Updates to appendices regarding oxygen use by ECSWs	V4.02	14/05/2013
Wendy Hampson	Updates to PTS Appendices	V4.02	09/05/2013
Andy Collen	Clarification around autonomous use of oxygen	V4.02	08/05/2013
Andy Collen	Change in role title in PTS appendix	V4.01	23/04/2013
Nicola Brooks	Minor amendment to Appendix L regarding DBS and registration	V3.02	13/03/2013
Jane Pateman	Approved by Chair's action due to postponement of CGWG meeting	V3.01	12/02/2013
CGWG	For approval (meeting postponed, comments sought offline)	V3.01	05/02/2013
Andy Collen	Addition of new appendix: 111 Clinical Advisor/ 111 Senior Clinical Advisor	V3.01	29/01/2013
RMCGC	Approved	V3.00	22/10/2013
CGWG tele conf	Approved according to authority to approve changes	V2.02	22/10/2012

	to appendices		
Voluntary Services Department	Updates to CFR appendix	V2.01	15/10/2012
Final version	Approved	V2.00	05/07/2012
RMCGC	For approval	V1.06	05/07/2012
Wendy Hampson/Andy Collen	Alterations and additions to PTS Appendices	V1.05	22/06/2012
SPF members	Further clarifications	V1.04	12/04/2012
CGWG	For approval	V1.04	10/04/2012
Staff side representatives	Discussion	V1.03	10/04/2012
Andy Collen	Revisions following SCOT	V1.03	28/03/2012
SCOT members	For comment	V1.02	28/03/2012
Andy Collen	Revisions	V1.01	13/03/2012
Temporarily withdrawn		V1.00	27/02/2012
RMCGC	Approved at RMCGC	V0.02	10/11/2011
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Jo Byers	First Draft	V0.01	18/09/2011
Andy Collen	First Draft	V0.01	14/09/2011

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Review Due

Manager	Andy Collen	
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Supports Standard(s)/KLOE

	Care Quality Commission (CQC)	**IG Toolkit**	**Other**
Criteria/KLOE:	C1.5; C1.6; C1.7; R2.1; R2.2; R2.3; R3.1; E1.1; E1.2; E1.5; E3.1; E6.1; W2.4; S1.4; S3.11; S3.13; S3.14		