DRAFT – NOT FOR IMPLEMENTATION

Ambulance Control Procedure Practitioner Deployment

National Ambulance Service (NAS)

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1.0 POLICY STATEMENT

1.1 The National Ambulance Service's (NAS) responsibility is to deliver pre hospital emergency care in a timely manner to any person who calls for our help (by 999 call or GP urgent calls).

1.2 The NAS facilitates this by means of deploying Emergency Ambulances, Rapid Response Vehicles (including Motorcycles and Officers) and Intermediate Care Vehicles. These resources may be crewed by individuals or a multiple of staff.

1.3 The Health Information and Quality Authority (HIQA) has published Response Times and Quality Standards for Pre Hospital Emergency Care. The NAS's performance is benchmarked against these standards

2.0 PURPOSE

2.1 To ensure that all Control Supervisors and Staff are aware of the principles of deployment focussed on positively influencing clinically effective response times to emergency and urgent calls

2.2 To provide NAS staff, and in particular, Ambulance Control Supervisors and Staff, with clear and unambiguous guidelines when deciding on resource deployment

2.3 To ensure the safety of NAS staff who are responding to an emergency or urgent call and to ensure the correct delivery of patient care to the public.

2.4 To ensure that NAS can target the correct type and clinical skill mix (Advanced Paramedic, Paramedic and EMT) of resources to match each patient's needs.

2.5 To outline the principles to be adopted in relation to double crewed resources (EMS and ICS) and single crewed resources (RRV/MRU) in relation to the deployment and use of standby points.

2.6 The use of standby points and the location of emergency resources within a specific area is a critical component of the NAS Spatial and Tactical Deployment approach to respond rapidly to patients. A great deal of analytical and planning work has been undertaken in conducting a Spatial Analysis of demand for services and determining the optimum position for a vehicle(s) within a given area.

3.0 SCOPE

3.1 This Procedure applies to all Managers, Supervisors, and Staff

4.0 LEGISLATION/ RELATED POLICIES/PROCEDURES

- HIQA Pre Hospital Emergency Care Response Times and Quality Standards
- PHECC Emergency Medical Dispatch Standard
- PHECC Clinical Practice Guidelines
- PHECC Spatial Analyses
- Policy – NASWS011- Protection of Lone Workers

5.0 GLOSSARY OF TERMS AND DEFINITIONS

5.1 **EMS** – Emergency Medical Service
5.2 **ICS** – Intermediate Care Service
5.3 **EMT** – Emergency Medical Technician
5.4 **Priority Zones** - Areas of high activity Category 1 (Echo/Delta) category calls can be classified as Priority Zones.
5.5 **Drive Zones** – Routes between area high activity Category 1 (Echo/Delta) category calls can be classified as Priority Zones

6.0 ROLES AND RESPONSIBILITIES

6.1 CONTROL AND PERFORMANCE

6.1.1 NAS Control Managers are responsible for ensuring compliance with this Procedure.
6.1.2 NAS Control Managers are responsible for ensuring that Advanced Quality Use Assurance is carried out to determine compliance with the PHECC EMS Dispatch Standard
6.1.3 The Control and Performance Manager is responsible for monitoring managerial compliance with this procedure and providing related reports to NAS Area Operations Managers

6.2 AREA OPERATIONS

6.2.1 NAS Area Operations Managers are responsible for ensuring effective rostering and availability of staff
6.2.2 All operational staff are responsible for adopting a flexible and dynamic approach to deployment focused on meeting the needs of patients

6.3 MEDICAL DIRECTORATE

6.3.1 The Medical Directorate is responsible for reviewing AQUA Audit and HIQA Response Times and Quality Standards with a view to making recommendations to make changes to the Tactical Deployment Plan

7.0 PROCEDURE

7.1 PERFORMANCE MANAGEMENT PRINCIPLES

7.1.1 NAS will use Response Times and AQUA Audit performance reports to refine the deployment to, the use of, and the dispatch from standby points throughout Ireland. This could lead to changes in Priority Zones, Standby Points and Tactical Deployment Plans. The overriding principle is that standby is an integral part in enabling healthcare to be at the patient side in the shortest possible time.

7.1.2 Individuals will be personally accountable for their performance in accordance with this procedure. The framework set by this procedure outlines NAS standards which are expected of staff who will be managed and supported to achieve these standards.

7.1.3 The latest version of any Tactical Deployment Plan will alter depending on hour, day and season. NAS will employ the most effective performance management tool to enable appropriate modification to dispatch protocols and identification of Priority Zones and Standby Points.

7.2 CLASSIFICATION OF STANDBY POINTS

7.2.1 No Standby Points should be used unless risk assessed and the star rating has been agreed by local management and staff.

7.2.2 Standby Points must be located strategically to ensure effective response to patients. Safe sign off of Zero star standby points enables RRVs to be utilised in conjunction with Policy – NASWS011 – Protections of Lone Workers.

7.2.3 Standby Points are designated a star rating dependent on the facilities available at that location, i.e.:

0 Stars A 0 star point has no facilities i.e. roadside location **1.0 hour (60 minutes) Maximum. This can be extended through mutual agreement between the staff member/members and Ambulance Control.**

1 Star A 1 Star point has limited facilities e.g. toilets and basic refreshments and is suitable for unlimited standby. **There is unlimited maximum standby duration at a 1 Star Point**

2 Stars A 2 Star point has full dedicated facilities including communications and rest area. This is suitable for:

- Meal break
- Facilities break
- Vehicle check and restocking
- Has facilities that make it suitable for unlimited standby

Please note it is rare for such facilities to be in a high demand area so it is unlikely that sites such as this are in the Tactical Deployment Plan; therefore time at these points should be at Ambulance Control discretion. Not all 2 Star points have restocking facilities. **There is unlimited maximum standby duration at a 2 Star point.**

3 Stars **Ambulance Station -** Full dedicated facilities including communications and rest area. This is suitable for a meal break, facilities use, and vehicle check/restocking.

Special Some points have a variety of facilities and may be used for refreshments points and limited standby; this may be due to co-location in another building e.g. some Fire Stations, Garages, etc. or proximity to the public. The standby time at points such as this will be agreed locally between local management and staff following a risk assessment and rated in line with this procedure.

7.3 HOURS OF OPERATION

7.3.1 Standby points will operate 24 hours a day, 7 days a week

7.4 DEPLOYMENT METHODOLOGY

7.4.1 Crews will have logged on at the very start of their shift; this log on will be confirmed with the Ambulance Control during radio check. Crews will be available for and dispatched to, Standby Points with particular emphasis on Priority Zones. The procedure to confirm log on during radio check may change due to the implementation of Digital Radio technology

7.4.2 A crew can be at standby until the time where they can return to base before the end of their shift e.g. the crew must be allowed to return to base from standby so that they are on base by the end of their shift.

7.4.3 Where a crew on standby needs to re-stock the vehicle before the end of shift, Ambulance Control will authorize the crew to return to base when there is half an hour of their shift remaining so as to allow for restocking. Specific requests to return to a serviced point for Station administration will be considered by Ambulance Control on an individual basis depending on operational demand.

7.4.4 When directed to do so by Ambulance Control, staff will proceed immediately to their designated standby point. If a crew are dispatched to standby and find, for whatever reason, that they are unable to deploy, they should raise the issue with Ambulance Control immediately.

7.4.5 Any operational factors e.g. vehicle defects, that make a crew unavailable for any reason must be communicated to Ambulance Control immediately.

7.4.6 Ambulance Control will dispatch to the designated standby point to be used. On arrival, the crew will confirm "at standby". Resources will be rotated through standby points, to ensure maximum coverage of the designated Priority and Drive Zones.

7.4.7 Cover at Zero Star standby point will be restricted to 1.0 hour (60 minutes), excluding driving to and from the standby point. During times of extreme weather (definition of extreme weather: any environmental temperature that compromises the safe working temperature inside the vehicle to below 16 degrees centigrade). It is noted that it is unlikely to go below this temperature in a vehicle that is running therefore (*In periods of colder weather – where the ambient temperature is below freezing for extended hours, particularly during the night, consideration will be given to reducing the period of standby at Zero Star points to less than 1 hour. Such provisions will be made in consultation between the Control Supervisor on duty and will not be unduly withheld, due consideration being given to staff welfare and patient response needs.*

7.4.8 If crew leave their vehicle, whilst at standby, they must take the following items of equipment (where issued), with them and remain within 30 seconds of the vehicle (please note some standby points have logistical challenges that will make it difficult to achieve the target and this is recognised at a local level):

- Pager (where appropriate)
- Radio handset
- Mobile phone

7.4.9 Ambulance Control and staff will work together to ensure that vehicles on a Zero Star standby point are moved after 1.0 hours (60 minutes), for a facilities break, allowing staff enough time to use the facilities. The allocated time for facilities breaks will be 15 minutes and vehicles are clear for deployment to 999 calls at any time. There is no limit in terms of the amount of time spent on standby, during any one shift. Motorcycles will have locally agreed procedures for standby.

7.4.10 Staff request for facilities (see 7.4.9) will be accommodated and honoured where reasonable; these will be at the most local NAS or HSE recognised star facility in the area, unless specific requirements for welfare create a need to return to another suitable location: for example change of uniform or health requirements.

7.4.11 Ambulance Control will make every effort to share workload and standby duties across all crews however it must be acknowledged that this is dependant on the current level of activity, availability of vehicles, distance to the standby point and skill mix of crew.

7.5 ON DAY DYNAMIC RESOURCE MATCHING

7.5.1 Any specific requirements relating to the patient's needs during their transportation must be requested at the time of booking so as to ensure the ESP is fully informed

7.5.2 Ambulance Control are expected to match resource type, i.e. Rapid Response Vehicle (RRV), Emergency Ambulance (EA) or Intermediate Care Vehicle (ICV) to the daily demands placed on the NAS. This will be facilitated by the movement of personnel from one resource type to another, as and when deemed necessary by the Ambulance Control (i.e. RRV staff x two report for duty and could be moved onto a EA for part or all of the shift – and vice versa, EA crew could be moved onto two x RRV).

7.5.3 The movement of personnel to specific types of resources will only occur where those staff are suitably experienced/trained for those particular types of resources.

7.5.4 Where a member of staff is moved to a different resource or location to match on day demand, Ambulance Control staff and the affected member of staff will co-operate to ensure they are returned to their original location to facilitate them finishing on time at their original starting location. It should be noted, however, that this may not always be possible, due to the exigencies of the service.

7.6 TARGETING CLINICAL SKILLS TO PATIENT NEED

7.6.1 All skill levels will be targeted in line with the PHECC EMS Dispatch Standard as determined by the relevant AMPDS Dispatch Code and Determinants.

7.6.2 In addition to AMPDS determinations, Advanced Paramedics should be dispatched to:

A. Calls identified by GPs as "Emergencies".
B. As requested by a Paramedic on scene
C. As directed by an Ambulance Officer.

7.7 PRACTITIONER SAFETY

7.7.1 Any Practitioner operating in a single responder role will have authorisation to activate the mobile repeater independently to ensure continuity of contact with "lone workers".

7.7.2 RRVs will not be allocated to any call where verbal or physical conflict is suspected unless the Gardai are already in attendance.

7.7.3 RRVs will be contacted if they have failed to log off 15 minutes after expected return to base.

7.7.4 Each RRV will have a mobile phone for contingency communications.

7.8 INTERPRETATION

7.8.1 Where a Paramedic/Advanced Paramedic seeks to dispute their deployment in either an RRV or EA or in supporting spatial geographical cover at a Standby Point, then that Paramedic/Advanced Paramedic should be advised to carry out the allocated duty "under protest" if necessary, and discuss the matter with their respective Supervisor. Record the event in the Control Shift Incident Report.

7.8.2 This Procedure is not intended to provide guidance for every eventuality. Where services are "demand led" unprecedented situations will arise that have not been reasonably foreseeable. Such situations will be considered in the document review.

8.0 IMPLEMENTATION PLAN

8.1 This Procedure will be circulated electronically to all Managers, all Supervisors and Staff

8.2 This Procedure will be available electronically in Ambulance Control for ease of retrieval and reference

8.3 The Control Manager responsible for updating Procedure Manuals will return the Acknowledgement Form to NAS Headquarters to confirm document circulation to all staff.

9.0 REVISION AND AUDIT

9.1 This Procedure will remain under constant review and may be subject to change to facilitate any changes/developments in service requirements.

9.2 Control Managers have responsibility for ensuring the maintenance, regular review and updating of this Procedure.

9.3 Revisions, amendments or alterations to the Procedure can only be implemented after consultation with relevant stakeholders and approval by the relevant senior manager.

9.4 This Procedure will be formally reviewed wherever circumstances, a relevant event or legislative change dictates.

10.0 REFERENCES

Non Applicable

11.0 APPENDICES

Appendix I - Procedure Acknowledgement Form
Appendix II – PHECC EMS Dispatch Standard