NATIONAL CLINICAL BULLETIN 001/2022

Clinical Decision Making Framework 2022

Healthcare delivery is becoming increasingly complex, with a growing range of options for patients and healthcare professionals, to ensure people receive the right care at the right time. The modern ambulance service continues to respond to a high demand for emergency care, although in addition is also required to respond to patients presenting with health concerns that are not of an 'emergency' nature – currently described as 'urgent' or 'unscheduled' care.

To support frontline clinicians with decision making in these situations, a Clinical Decision Making Framework was introduced in 2017 and updated in early 2020. In response to feedback and development of tools, we are pleased to be able to circulate an updated 2022 version. One of the main additions is the summary infographic highlighting the key elements of shared decision making (on page 4 of this bulletin).

This framework contains a range of guiding principles and has been developed to assist ambulance clinicians to make safe, effective, person centred decisions with patients and carers, and is aligned to the principles of Realistic Medicine. The framework is in addition to our existing clinical guidance, and can be accessed from this bulletin, the JRCALC app and @SAS.

Some key content related to Realistic Medicine, shared decision making and safety netting will be covered in Learning in Practice in 2022. We trust you will find this framework helpful and, taken with the additional LiP sessions, will be useful for improving patient and staff experience.

Clinical Decision Making 2022

A Framework for Safe, Personalised Care & Shared Decision Making.

Linked documents:

- **UK Clinical Practice Guidelines (JRCALC)**
- **SAS Scope of Practice Framework**
- **SAS Clinical Documentation Guideline**
- **SAS Confirmation of Death Guideline**
- **Realistic Medicine**
- **Shared Decision Making (NICE)**

Author: Patient Safety Manager
Clinical Assurance Group approval date: 25/11/2021

1. Introduction

The Scottish Ambulance Service (SAS) increasingly responds to a range of people with non-life threatening, complex health and social care needs. Around 86% of 999 calls to SAS are not categorised as life threatening emergencies, and SAS currently does not convey approximately 35-40% of these non-life threatening calls to hospital; utilising alternative care pathways, referral to another health care professional or giving self-care advice instead. This is a shift from the traditional model of taking all patients to hospital, to one where the ambulance service contributes to ensuring that patients receive the right care, in the right place, at the right time, first time.

This framework has been developed to assist ambulance clinicians reach safe and effective shared decisions with patients as appropriate. These shared decisions will often be for the person to be transported to hospital, although on occasion it may be more appropriate for the person's care to be managed in another way. This framework offers background information, guidance and tools related to consultation, shared decision-making, professional-to-professional referral, early warning scoring systems, safety netting and patient care records to support safe outcomes.

The SAS previously used a system of 'see & treat' guidelines to support ambulance clinicians in their decision-making related to specific non-life threatening conditions and circumstances. However, due to the complexities and co-morbidities of an individual's health, in addition to considering their values and wishes, it can be challenging to specify one guideline for each condition. Therefore, 'see & treat' guidelines should no longer be used and the guiding principles in this document should be adopted instead.

In conjunction with the SAS Education and Professional Development Department, this framework will complement new and existing education of our clinicians in line with each grades' scope of practice. This framework is informed by relevant literature and is also aligned to the 'personalised care' and 'shared decision-making' elements of the Scottish Governments 'Realistic Medicine' strategy[1] and Shared Decision-Making Guidance set out by NICE[2]. This guidance must be considered in conjunction with UK JRCALC Clinical Practice Guidelines, SAS Clinical Guidelines and individual clinician scope of practice.

The key aspects of shared decision-making, outcome options and safety netting are illustrated in Fig 1 on the next page. The remainder of the framework offers further information to guide and support ambulance clinicians.

Scottish Ambulance Service
Taking Care to the Patient

Shared Decision Making

Key points in reaching a shared decision with patients regarding assessment, treatment and outcome options.

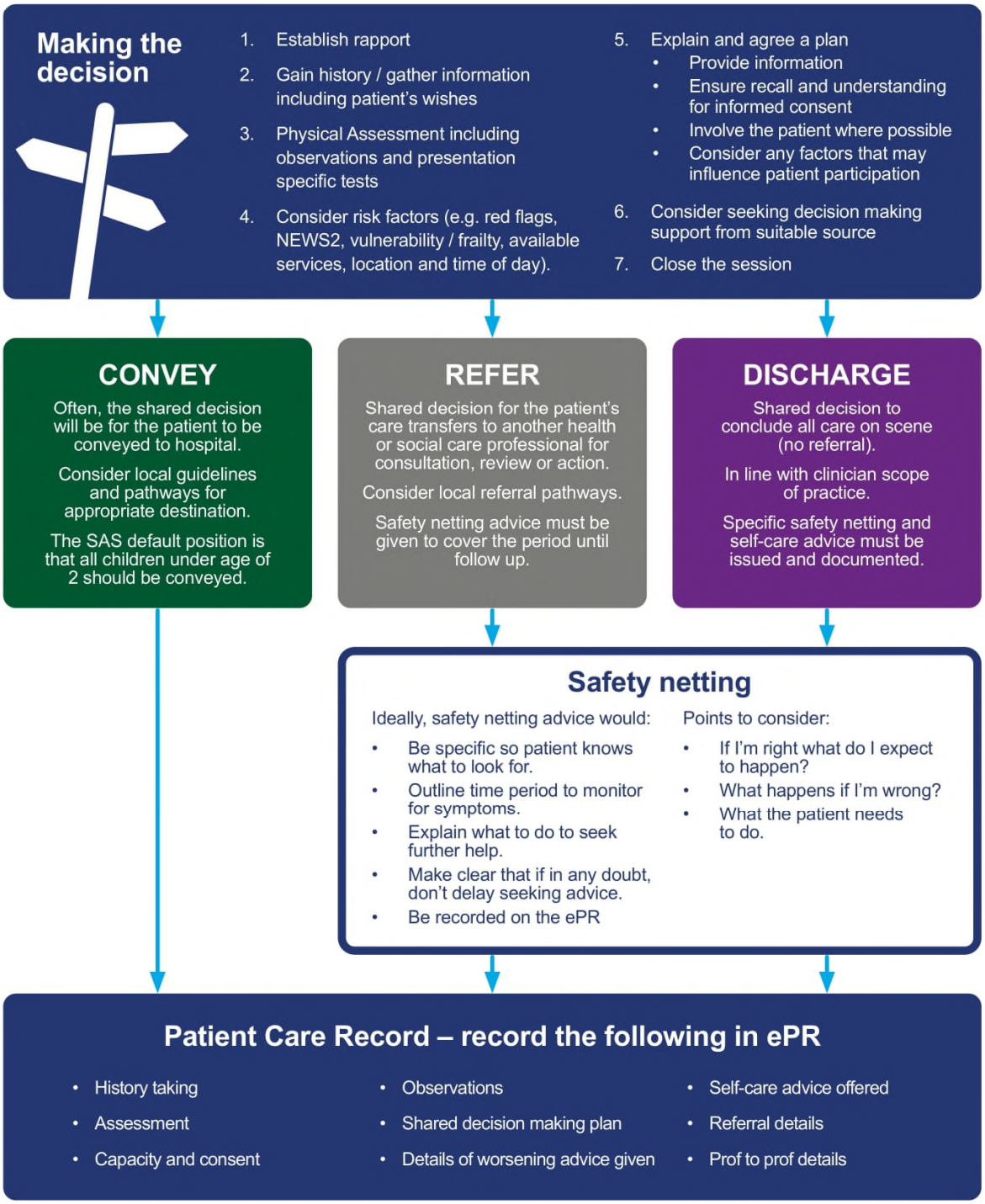


Fig 1: Key elements of shared decision-making, outcomes and safety netting.

2. Background to Decision-Making

Decisions can be made in a number of ways, depending on the circumstances and the experience of the decision maker.

In the 1960's, it was proposed that 'classical' decision-making was a rational, calculated process based on careful evaluation of the benefits and limitations of the options that were available at that point in time. However, this may not be possible when decisions need to be made with limited information or time.

In the 1990's, a concept of 'naturalistic decision-making' was proposed after studies of emergency responders reviewed decisions made in time limited, unpredictable and stressful situations. It was suggested that they made decisions based on previous experiences of being in similar situations and their 'intuition'.

These two ways of thinking have been referred to as 'System 1 – thinking fast' and 'System 2 – thinking slow'.[3]

Whilst many people believe they utilise System 2 thinking and slow, careful decision-making the majority of the time, some psychologists suggest that a subconscious System 1 approach is more prevalent. System 1 leads humans to instinctively make very fast decisions many times a day, during routine everyday life. System 2 can become activated if System 1 struggles to make sense of the situation and provide an option. It can be helpful to understand these two system principles, in order to recognise when it may be useful to attempt to actively initiate System 2 to consider options for and with the patient.

This evolution of decision-making theory has been further sub-divided into the following methods:[4]

	Way of thinking	Decision-making method
System 1	operates automatically and quickly, with little or no effort or sense of voluntary control	• Recognition Primed decision-making ('intuitive thinking') • Rule Based decision-making*.
System 2	thinking and decision-making that takes concentration, time and effort to consider choices, with applied reason	• Choice decision-making • Creative decision-making • Rule Based decision-making*

*Rule based decision-making can be in both depending on knowledge of, and access to the rule.

Ambulance clinicians are regularly in situations where one or more of the methods above require to be adopted, often without knowledge or awareness that it is occurring. Each of these methods has benefits and limitations, which are outlined below:

Recognition Primed (intuitive) Decision-Making

Many experienced clinicians can intuitively identify when a specific situation is present, e.g. a person experiencing an acute stroke. This can be a very fast method, requiring little conscious thought, although it does require experience (hence why novice clinicians may not reach the same conclusion as quickly). It can be affected by confirmation bias leading to failure to consider a differential diagnosis. It is important to note that this all happens sub-consciously, therefore the challenge is to gain awareness of it at the time.

Rule Based Decision-Making

There are a number of rules for ambulance clinicians to apply: JRCALC Clinical Practice Guidelines, Patient Group Directives (PGDs), SAS Clinical Guidelines and SAS Standard Operating Procedures (SOPs). These can be helpful as they provide the course of action that has been decided by others, which should be applied in certain situations. However, it requires knowledge of the rule's presence, easy access to the rule and for the correct rule to be applied. If the rule has been learned well and is embedded in long-term memory, it can be applied quickly by a system 1 response. If not, system 2 would be initiated to review and apply the rule.

Choice Decision-Making

This is a method of comparing options after the problem has been identified. Origins are from the 'classical decision-making' mentioned above. This allows the best option to be implemented, although it usually requires time and can be affected by distracting environments and stress.

Creative Decision-Making

An infrequently used method requiring a novel solution to an unfamiliar problem when intuition, rules and choices fail to identify a course of action. While it may identify a solution, it is not normally recommended for high risk situations unless there is no alternative. It can also be time consuming and be affected by stress and environments. It may also be difficult to justify.

3. Cognitive biases

Biases in decision-making are essentially subconscious errors where judgement has been unduly influenced by other factors. Due to the speed of System 2 thinking, this method is very susceptible to bias. There are many different types of biases that can influence decision-making in pre-hospital care. The key ones to note are:

Bias	Description
Priming effect	Being recently exposed to something that subconsciously influences later decisions.
Anchoring bias	Focusing and relying too heavily on an initial piece of information and failing to adjust in light of further and later information.
Availability bias	Making a decision based on availability of recent memories or experience of making a similar decision.
Confirmation bias	Looking for and favouring information to support an earlier decision, while subconsciously discounting other information that doesn't support it.

4. Shared Decision-Making

Shared decision-making is a collaborative process, it involves the patient and the ambulance clinician working together to reach a joint decision about care[2].

Patients can often play a passive role in any decision-making related to their care, with clinicians often taking the lead for most of the decisions made. Feedback from patients and service users suggests that they increasingly wish to be involved in decisions relating to their care. Additionally, evidence suggests that involving people in their own care improves their experience and outcomes[1]. SAS is committed to providing care that is responsive to individual personal preferences, needs and values and to incorporate these factors into decisions where appropriate and possible.

In shared decision-making, the healthcare professional seeks to outline the options that are available to the patient, explaining the risks and benefits of each. The clinician must make it easy for the patient to explain what is important to them in the context of treatment options before agreeing a management plan.

It should be accepted and acknowledged that different patients may vary in their views on risks, benefits and consequences of treatment. These views may differ from those of their health care professional.[2]

Although patient participation in their own care is desirable, there are factors and influences that must be considered, as not all patients will be willing or able to contribute.[5] Factors that are likely to influence patient participation are:

Patient & illness related factors
Healthcare professional factors
Healthcare setting factors

Patient & illness related factors

<u>Cognitive capacity</u>
Any permanent or temporary cognitive impairment needs to be recognised as this will influence patient involvement. Capacity to consent and be involved in decisions needs to be assessed, deemed to be present and then documented.

<u>Stress & severity of illness</u>
Patients who present as emergencies may have limited understanding regarding what is wrong with them, and find it harder to engage in decisions related to their care, therefore leave all immediate decisions to healthcare staff. It may still be important to consider the views and wishes of patients during critical illness to ensure those wishes are considered.

Previous experiences

If someone has a new experience of ill health, they may be less likely to engage than someone who has had a number of previous similar episodes, and has a good understanding of their condition. Due to the availability of health information online, many patients will be well informed about their existing conditions.

Age & values

The traditional view of 'the clinician knows best' may still be experienced in many cases. In inviting a patient to comment on what they wish to happen, may illicit a response of 'I don't know, what you think?' This may be more apparent in the older generation.

Healthcare Professional Factors

Understanding of shared decision-making principles

The way that healthcare professionals interact with the patient can also affect the patients' participation. It is imperative that to achieve patient involvement, the ambulance clinician must appreciate the benefit of it, and how and when to facilitate it. The more experience that an ambulance clinician gains in involving patients, along with feedback, the easier they will find this.

Shallow authority gradient

Patients will understandably have concerns and find it difficult to challenge a healthcare professional or speak up with their contributions or concerns if the healthcare professional does not create an environment to enable the patient to do so. Encourage them to ask questions and ensure that you communicate using easily understood language.

Tiredness, hunger & fatigue

These well recognised elements are evidenced to affect human performance related to decision-making. Recognising when you or your colleague's decision-making is being affected is important to patient safety. Communication between crew members is essential as evidence shows that clinicians are poor judges of the deterioration of their own performance but can spot the effects of tiredness, hunger or fatigue in others.

Healthcare Setting Factors

Location

For safe shared decision-making, the patient should ideally be in a place of safety, e.g. at home or homely environment. The same situation may require a different plan depending on the location e.g. home, work or public place. If a shared decision to not convey or refer occurs in a work environment or public place, all reasonable steps must be taken to confirm that the person can get home safely, and has capacity to understand the safety netting advice given.

5. Informed Consent

The traditional model of consent as a requirement predominantly for invasive procedures or examination is evolving to one that includes patient involvement and shared decision-making.[6] These developments highlight a recognition that patients must have the benefits and limitations of treatment options outlined where appropriate, and that patients must be supported to make informed decision where they have capability to do so.

The capacity to understand the risks and benefits of treatment options, contribute to shared decision-making and the ability to give informed consent must be assessed for every appropriate patient.

Outlined below are the basic principles of patient capacity assessment to determine if the patient has capacity to make the decision needed at that time. Further guidance on full mental capacity assessment can be found in the UK Clinical Practice Guidelines.

Receive	Can the patient listen and concentrate enough to receive information being disclosed to them?
Believe	Can the patient understand, accept and believe the information being explained to them?
Retain	Can the patient remember the information being explained long enough to consider and analyses? Do they demonstrate the ability to remember information after you will have left the scene?
Explain	Can the patient explain the information they have received, and the risks involved with their clinical condition in their own words?

If the answer to all of these questions is ‘yes’, then the patient has capacity to make the decision.

If the patient clearly does not have capacity and is unable to consent in the emergency situation e.g. lowered level of consciousness due to illness or injury, you must act in the patient’s best interest, initiating treatment and transporting to the Emergency Department.

If the patient is deemed not to have capacity to give informed consent and conveyance to hospital will be difficult e.g. acute mental ill health, then further support must be sought from other services, e.g. GP, out of hours, social services, ambulance control, and police.

6. Patient Assessment and Consultation

Traditional assessment strategies that have been taught in ambulance clinician education are primary and secondary surveys. Primary surveys consist of the widely used catastrophic haemorrhage, airway, breathing, circulation, disability and exposure (CABCDE) structure, and is the recommended approach for assessing deteriorating or critically ill patients.[7] Further (secondary) assessment most often consists of what is recognised as the traditional medical model (figure 2).

When patients do not have any immediate or life-threatening problems, the secondary assessment becomes the point when key information can guide and influence decision-making and management. The traditional medical model is a functional model for tackling the problem of what is wrong with the patient, although is limited in considering wider matters such as the patients' opinion, values, understanding and the effects of their illness on their life.

Traditional Medical Model

- Presenting complaint
- History of presenting complaint
- Past medical history
- Family history
- Social history
- Drug and allergy history
- Systems review

Figure 2

General Practitioner (GP) teaching and practice involves use of consultation models as an expansion to the medical model. This is an approach that can be adopted by ambulance clinicians when appropriate.

A consultation is a two-way encounter between a clinician and a patient. The use of a model gives a structure to the consultation and there are a number of different models, some that are more weighted to what the clinician thinks and decides, and others that are much more person-centred.

The use of a patient-centred consultation model during non-emergency patient contacts can be an effective method to involve patients in decisions related to their own healthcare and to empower them to state what matters to them, leading to increased satisfaction with their experience.

The Calgary-Cambridge guide is one of a number of consultation models that can be used to structure a clinical conversation and is popular in the UK. It is evidence-based in relation to communication between clinician and patient, and importantly leads to shared decision-making where appropriate.[8]

Figure 3 below shows how the Calgary-Cambridge Guide can be incorporated into patient assessment approaches and figure 4 illustrates each step of the process. Appendix A offers further detail of the content of each stage of the guide.

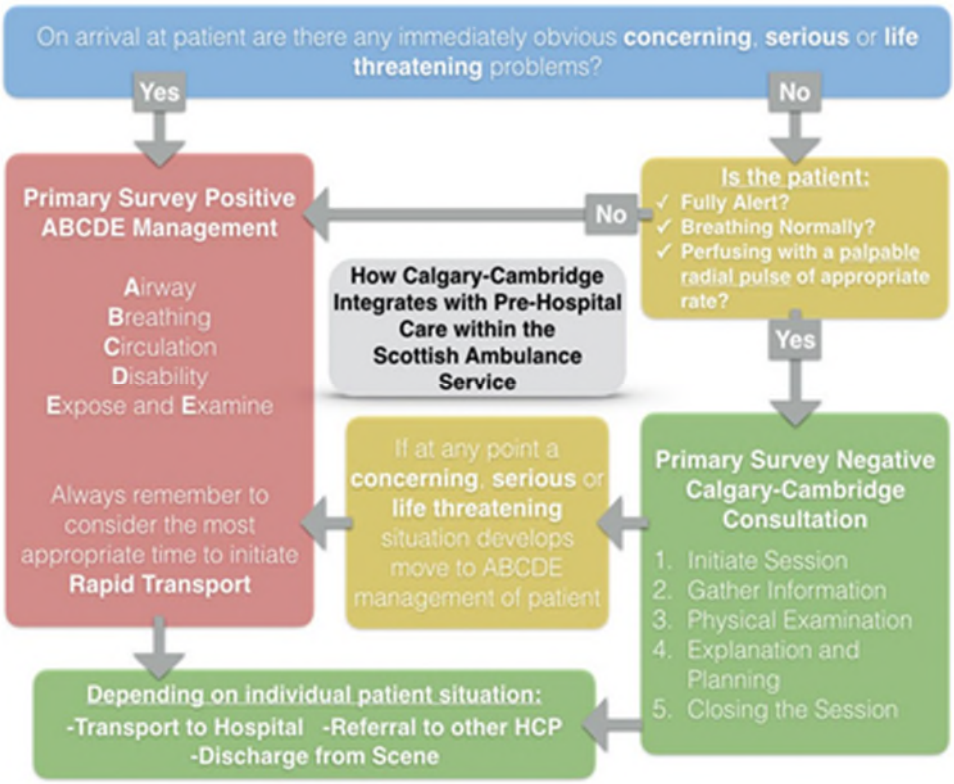


Figure 3: Incorporating Calgary-Cambridge into patient assessment strategy

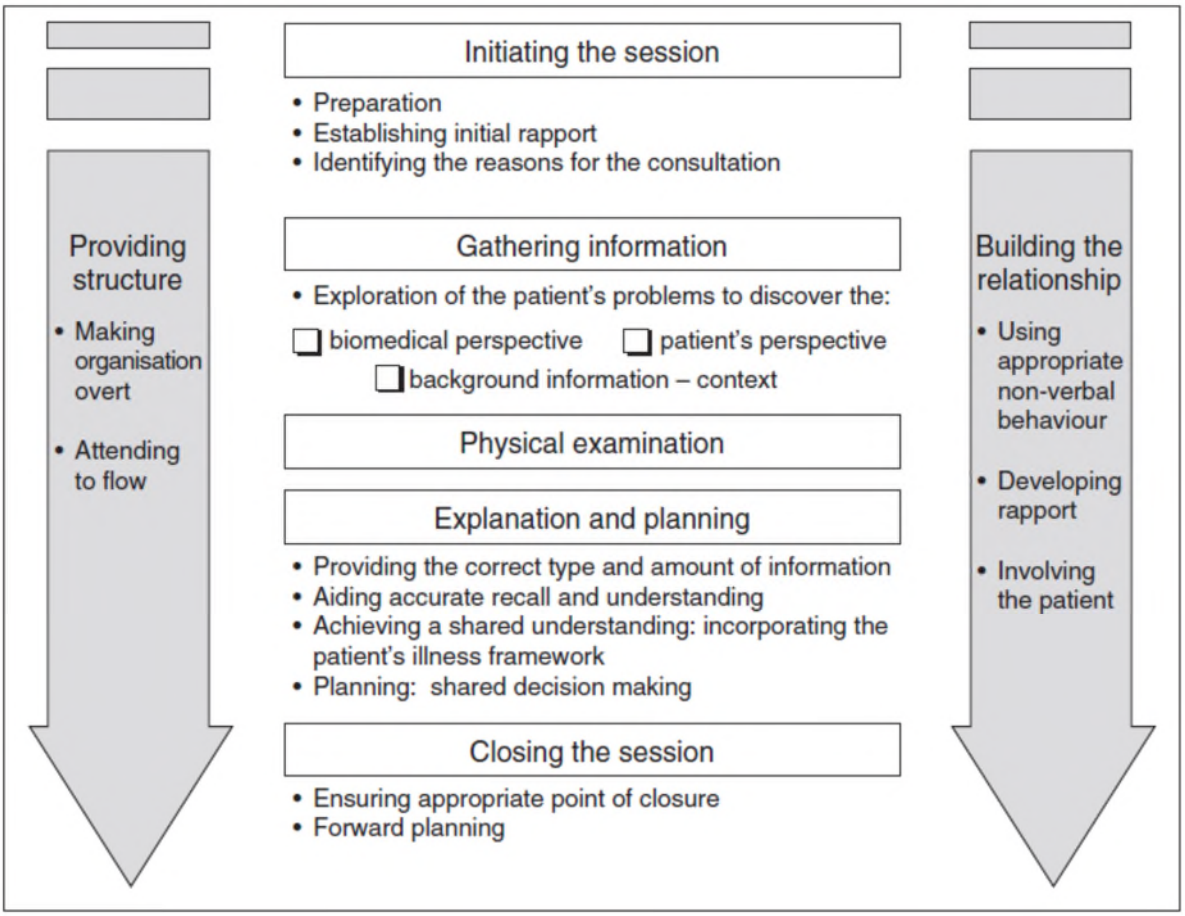


Figure 4: Calgary-Cambridge Guide

7. Considering Clinical Risk

National Early Warning Score 2

NEWS2 is an evidence based tool that assists with the identification of patients at risk of critical illness and supports clinical decision-making during patient assessment. It must not be used in isolation to make decisions.
The final score can help identify some high risk patients and is particularly effective at supporting early recognition of sepsis. NEWS2 does not provide a diagnosis, only a patient's level of risk and there are some conditions that do not trigger a high score.
Hospitals also use NEWS2, therefore it provides standardisation of assessment and language. It provides a score in response to six measured observations. A score is also added if supplemental oxygen is administered. The observations included are:

1. Respiratory rate
2. Oxygen saturations
3. Systolic blood pressure
4. Heart rate
5. Level of consciousness
6. Temperature

The ePR will calculate a NEWS2 score only when all six required observations are entered. Plastic lanyard aide memoires have been issued, and a breakdown of the scoring system is illustrated in table 1 below.

NEWS 2 can be used with adults aged 16 or older. It is not recommended for use in children or pregnant women due to different baseline physiological parameters. SAS are currently exploring the value of PEWS (paediatric) and MEWS (maternal) tolls for pre-hospital application.

Table 1: NEWS2 scoring system

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Table 2: NEWS2 thresholds and triggers

NEWS2 Score	Clinical risk
0	Low
Aggregate 1-4	
Individual parameter scoring 3	Medium
Aggregate 5-6	
Aggregate 7 or more	High

Medium & high risk
A NEWS2 score of 5 or over, or an individual parameter scoring 3, in a patient who is feeling unwell is generally considered to identify a potentially critically unwell patient.
This should also trigger the question 'could this be due to infection or sepsis?' Urgent transfer to ED is required with consideration given to passing a stand by call to the receiving unit.

Low risk
Patients with a NEWS2 score between 0-4 may be at low risk of critical illness at that time, however a low score does not exclude serious illness.
Some patients may be acutely unwell and have a low NEWS2, e.g. chest pain, stroke, headache.
It is noteworthy that patients who are in hospital with a NEWS2 score between 1-4 would normally have their observations measured, recorded and monitored every 4-6 hours.
Therefore, a patient presenting in pre-hospital with a NEWS2 aggregate between 1-4 will likely require further assessment or follow up, particularly if other co-morbidities or risk factors are present.
If the patient is not conveyed, consider appropriate referral or professional to professional discussion with GP, OOHS, NHS24 or Advanced Practitioner.
It is important to note that some patients with chronic conditions may have elevated NEWS2 as their normal baseline, e.g. COPD.

Children

Paediatric Early Warning Scoring systems do exist for children, however JRCALC promotes the value of utilising a traffic light system for assessing risk of critical illness in children, particularly when a fever is present.

Table 3: NICE traffic light system for identifying risk of serious illness in children.

	Green – low risk	Amber – intermediate risk	Red – high risk
Colour (of skin, lips or tongue)	• Normal colour	• Pallor reported by parent/carer	• Pale/mottled/ashen/ blue
Activity	• Responds normally to social cues • Content/smiles • Stays awake or awakens quickly • Strong normal cry/not crying	• Not responding normally to social cues • No smile • Wakes only with prolonged stimulation • Decreased activity	• No response to social cues • Appears ill to a healthcare professional • Does not wake or if roused does not stay awake • Weak, high-pitched or continuous cry
Respiratory		• Nasal flaring • Tachypnoea: – RR >50 breaths/ minute, age 6–12 months – RR >40 breaths/ minute, age >12 months • Oxygen saturation ≤95% in air • Crackles in the chest	• Grunting • Tachypnoea: RR >60 breaths/minute • Moderate or severe chest indrawing
Circulation and hydration	• Normal skin and eyes • Moist mucous membranes	• Tachycardia: – >160 beats/minute, age <12 months – >150 beats/minute, age 12–24 months – >140 beats/minute, age 2–5 years • CRT ≥3 seconds • Dry mucous membranes • Poor feeding in infants • Reduced urine output	• Reduced skin turgor
Other	• None of the amber or red symptoms or signs	• Age 3–6 months, temperature ≥39°C • Fever for ≥5 days • Rigors • Swelling of a limb or joint • Non-weight bearing limb/not using an extremity	• Age <3 months, temperature ≥38°C* • Non-blanching rash • Bulging fontanelle • Neck stiffness • Status epilepticus • Focal neurological signs • Focal seizures
CRT, capillary refill time; RR, respiratory rate * Some vaccinations have been found to induce fever in children aged under 3 months			
This traffic light table should be used in conjunction with the recommendations in the NICE guideline on fever in under 5s.			

Serious illness

JRCALC encourages assessment of Red Flag signs and symptoms for a number of conditions. SAS are specifically highlighting the five common clinical presentations in Fig 5 for particular focus and consideration in relation to conveyance decisions with patients.

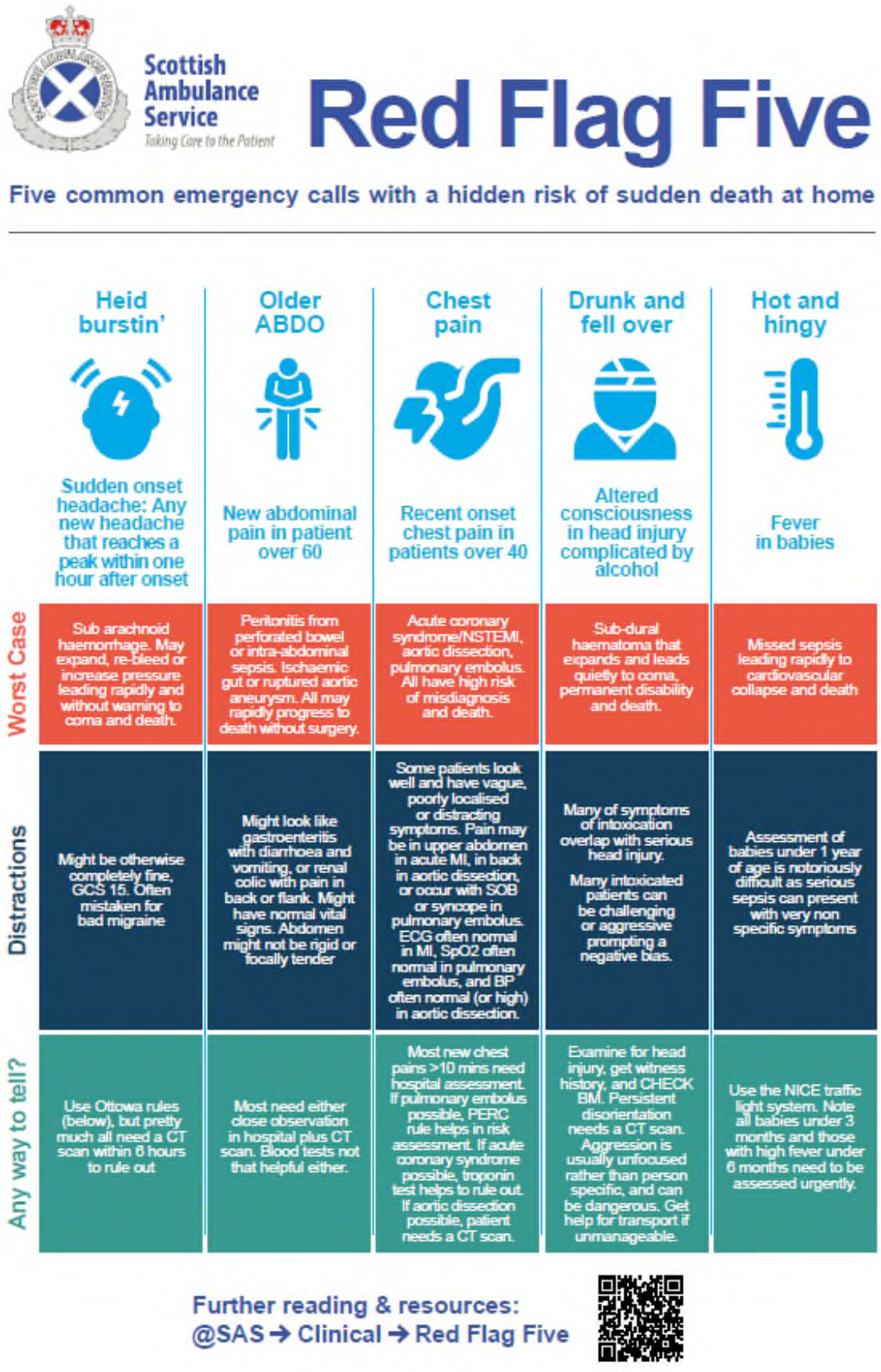


Figure 5: Specific clinical presentations to carefully consider in relation to conveyance decisions

8. Agreeing and Implementing the Plan & Right Care

Once a consultation and assessment have been completed, clinicians should discuss the **B**enefits, **R**isks, **A**lternatives, and if I do **N**othing (BRAN) with the patient in order to formulate the plan. Following this there are four end-points of care:

- Convey
- Referral (including Scheduled Care Appointment)
- Discharge on scene
- Refused

To ensure that the patient understands the plan, the Teach-Back method should be adopted. The four steps of the Teach-Back are:

1. Share information – Use simple, clear terms.
2. Check understanding – Ask the patient to repeat in their own words what they would tell a family member.
3. Re-phrase or clarify – identify and re-explain any misunderstandings.
4. Confirm understanding – repeat until you are happy that the patient understands.

Conveyance to hospital

- On many occasions, the shared decision will be for the patient to be conveyed to hospital. This should be to the most appropriate facility for their illness or injury, and in line with regional protocols and pathways.
- It may be challenging for SAS clinicians to know of the specific investigations, services, and treatments available at any given time of day across multiple care venues, therefore seeking local guidance may become more advisable.
- As Flow Navigation Centres become established across the country, decision and destination support will be available from local senior clinical decision makers to assist crews in getting patients the right care, in the right place, at the right time.
- Information can also be accessed on the SAS app or from ACC for crews who find themselves responding out-with their normal area.
- It is the default position that all children aged under 2 should be conveyed to hospital, and it is recommended that all older children are also conveyed unless an agreed alternative pathway can be arranged.
- Full patient record records must be completed and handed over to the receiving clinician during handover.

Referral to another healthcare professional or alternative pathway

- A referral is an episode of care which is passed to another healthcare professional for consultation, review, or further action. There is also usually a defined point at which responsibility for the patient's care transfers to the other healthcare professional.
- It is important to note that a shared decision with the patient for them to seek further

healthcare advice after your attendance e.g. to contact their GP, out of hours, NHS24 or emergency department, is not a referral. This outcome is a discharge (see below).

- Referrals can be arranged directly, clinician to clinician or via a formalised alternative care pathway. You must always follow any pathway guidance for referrals made and the information you supply must be as full and accurate as possible, in order for the healthcare professional to take over duty of care for the patient.
- Increasingly, referrals will include a scheduled appointment, which may be virtual or face-to-face at various care venues including Emergency Departments, Urgent Care Centres, Primary Care Centres or Minor Injury Units. Patients may be provided alternative transport arrangements or make their own way to such appointments, if safe and appropriate to do so (i.e. driven by a family member).

Preparing for a referral or scheduled appointment request:

- It is important to be fully prepared before making a referral or request for a scheduled appointment. Do not be tempted to try to refer a patient for whom you have not fully consulted with.
- Even if the referral is obviously indicated, the person taking the referral may not accept the patient without the full facts upon which to accept the patient. When making a referral, it is best to be fully prepared and have all information to hand.
- You may wish to use SBAR or ATMIST as structures to record the key points that you wish to put across. Try to be concise regarding the key points and why a referral is being made/requested. Ensure that you obtain and document the name and role of the person you are speaking with.

As a minimum, you should have the following information to hand when making a referral:

- Name, DoB, CHI Number (if available)
- GP details
- Presenting Complaint
- History of Presenting Complaint
- Relevant physiological observations
- Impression/working diagnosis
- Purpose of referral
- Consent status
- Patients expectations and wishes
- Allergies
- Social history
- Previous Medical History
- Current Medications

Be professional and confident when making a referral, ensuring that you make a clear case for referral as a safe alternative to taking the patient hospital. The person that you are referring the patient to, like you, may be under pressure and will appreciate a courteous conversation.

If the referral is refused, you are entitled to ask why in order for you to record this, and pass this on to the hospital (if you then convey). If the referral is accepted, explain to the patient when and how the follow-up will happen. Safety netting and self-care advice must be given to cover the period until the follow up.

You must then document details of the assessment, shared decision-making, referral conversation and safety netting advice on the ePR, with a copy left with the patient. Consider utilising the checklist in appendix B to guide decision-making.

Discharge on scene

There will be occasions where assessment and/or treatment can be concluded on scene, and a shared decision reached to be not to convey to a hospital, or refer to an alternative care pathway or another healthcare professional. This is considered a discharge from scene. Therefore, appropriate self-care advice including safety netting advice is imperative and must be given to the patient.

The default position is that only paramedics and advanced practitioners can independently discharge a patient from scene. If ambulance technicians and newly qualified paramedics are presented with a case where it is perceived that a discharge with self-care advice is appropriate, then decision-making support should normally be sought from an appropriate registered healthcare professional. Ideally, this support should come from a SAS clinician i.e. regional on-duty paramedic or advanced practitioner, ACC clinician, or on-call senior clinician (available through contacting ACC).

It is vital that all parties involved understand the difference between a referral and discharge with self-care advice whilst ensuring that this is recorded accordingly in the ePR. It is acceptable to discharge patients although it must be recognised by the clinician and patient that this is what has happened.

It is imperative to be accurate and comprehensive when issuing self-care advice. A full patient record must be completed, documenting all aspects of assessment, differential diagnoses, shared decision-making, informed consent, risk explanations, self-care advice and safety netting arrangements/advice. A printout of the ePR must be left with patient, with the self-care advice specifically highlighted.

It should be noted that the JRCALC guidelines has many condition and situation specific guidance, advice and instructions. Therefore, these guidelines must be accessible and considered when making discharge decisions.

Self-care advice will also compliment safety netting advice, which is discussed in the next section. Consider utilising the checklist in appendix B to guide decision-making.

Whilst ambulance technicians and newly qualified paramedics should normally always seek decision support, paramedics may also wish to seek support from another clinician when considering discharging from scene and issuing self-care advice, therefore are encouraged to have a low threshold for doing so.

Refusal
A patient with capacity to understand the risks and benefits of proposed options is entitled to refuse assessment, treatment or transport from SAS clinicians. In this situation, it may be appropriate to re-consider if the reasons for the person's refusal have been fully considered within the consultation, or if there is an alternative plan that can be agreed with the patient.

If it is proving impossible to reach agreement with a patient who is demonstrating cognitive capacity and associated understanding of the explained risks of refusal, then all elements of the discussion should be documented on the ePR, and the patient invited to sign the refusal section of the ePR. This refusal form should not be used for any other situation and is only for use when a patient with full capacity refuses treatment, further referral or transport.

If a patient is deemed not to have capacity and is refusing care, advice should be sought from ACC/clinical hub, professional to professional (GP, ED or mental health colleagues) or Police regarding duty of care and their safety. The effects of alcohol and/or drugs (including prescribed medications) should also be considered when assessing capacity.

5. Safety Netting

- Safety netting is recognition that the possibility exists that the patient's condition may worsen at a later time, after the consultation e.g. if a patient presents in the early stages of an illness, it can be challenging to predict if the illness will be self-limiting or will worsen.

- Safety netting usually consists of advice related to existing or new symptoms that the patient should monitor for and take action in response to the advice. Using the Calgary-Cambridge Guide should ensure good communication and rapport with the patient and lead to support appropriate safety netting.

- A good example of safety netting is the advice given to a patient who has sustained a head injury. The patient (and the other adult who needs to stay with the patient) is advised to monitor for specific symptoms and seek appropriate healthcare if any symptoms present or worsen. It can be more challenging to give specific advice in situations of general illness.

- If you are unable to provide adequate safety netting advice, you should reconsider if the plan is appropriate or contact another clinician to help support safety netting.

Ideally, safety netting advice would:

- be sufficiently specific so that the patient knows what to look for
- outline the time period that symptoms should be monitored for
- explain what to do to seek further help
- make it clear that if the patent has any doubts, they should not delay seeking further medical advice
- Be documented on the ePR.

The patient must have sufficient cognitive function to understand the advice. Ask them to repeat what you have agreed, so that you can check their understanding.

It is the responsibility of the referring clinician to ensure that good patient safety netting advice is in place for any interrupted care period in the referral process or when a patient is being discharged. Safety netting advice given must be documented on the ePR.

There are three questions that can be considered when considering safety netting for referrals or discharges:[9]

1. **If I'm (clinician) right what do I expect to happen?** This is the anticipated course of the illness or injury based on all the factors available and considered. Usually, this anticipated course would be that the patient's condition improves.

2. **What happens if I (clinician) am wrong?** This question considers that the anticipated course of improvement has not occurred, or the condition has worsened. Information must be provided to the patient to assist them with recognising an undesirable course of illness, e.g. you may highlight "Red Flags". Condition specific Red Flag guidance is available in JRCALC Clinical Practice Guidelines.

3. **What you (patient) need to do**: Follow the self-care advice if anticipated course continues. Or follow advice given to seek further help in response to changes in symptoms or the presence of Red Flags. Give the levels of options for re-contact (NHS 24, own GP, ED and 999).

6. Clinical Patient Care Records

Clinical patient care records must be completed in line with the SAS Clinical Documentation Guideline.

All aspects of history taking, assessment, capacity and consent, clinical and shared decision-making, referral, discharge, refusal, self-care advice and safety netting must be recorded in the ePR.

A copy of the ePR must be given to patients who are referred or discharged. Consider highlighting key points on the print out related to self-care and safety netting advice. Developments are being explored to enable a digital version of the 'patient & carer advice form' in the future. The current hard copy of this form can still be utilised, although it is helpful to include safety netting advice on the ePR also.

7. Clinician Responsibility & Principles of Care

- All ambulance clinicians must recognise and work within their own scope of practice and act in the best interests of service users at all times.
- Clinicians have a professional duty of care to the patient regardless of clinical presentation or referral pathway used. This includes the duty to appropriately refer patients to other health services for further advice, care or services, when the delivery of care is beyond your own scope of practice.
- If you refer a patient to another practitioner, you must make sure that the referral is appropriate and that, so far as possible, the service user understands why you are making the referral.
- Ambulance clinicians are responsible for their decisions.
- A thorough consultation, assessment and examination must be completed relevant to the presentation and urgency.
- Clear, comprehensive and professional patient care records are essential for the patients' care journey. It is also a legal record of care.
- Any patient not taken to hospital must be well informed and appropriately safety-netted.
- Decision support tools should be used as required and reflect the acuity of your planned patient care pathway.
- Professional-to-professional decision-making support for clinicians should be used as an additional tool to aide on scene decision-making. A remote clinician who cannot see the patient can only give supportive advice, not specific instructions, particularly regarding non-conveyance. Professional-to-professional support should not be obtained to overrule SAS specific guidance. Where there is a conflict between the advice of another healthcare professional and SAS guidance, ambulance clinicians must follow SAS guidance and raise the issue at a later time.
- If there is any doubt regarding a patient's conditions, patients should be transported to the Emergency Department or their care discussed with an appropriate healthcare professional.
- Contemporary pre-hospital decision-making leads to a range of possible outcomes for patients. This could cause some concern with ambulance clinicians related to what would happen should a patient deteriorate after an episode of care. The SAS is fully committed to being a learning organisation and has established system focussed processes that are facilitated using the principles of psychological safety for reviewing events which have an unintended outcomes. SAS fully supports clinician's safe and effective clinical care and decision-making in line with current guidelines.

8. Scope of Practice

A clinician's scope of practice is the area or areas of your profession in which you have the knowledge, skills and experience to practice lawfully, safely and effectively, in a way that meets set standards and does not pose any danger to the public or to yourself.

This scope of practice aligns the clinician's clinical education, position within the organisation and operational guidelines and procedures. Clinicians must know the limits of their practice and

when to seek advice and/or refer to another professional. Working within the:

- UK Clinical Practice Guidelines (JRCALC)
- SAS Clinical Guidelines
- SAS Scope of Practice Framework
- Health & Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics
- Health & Care Professions Council Standards of Proficiency

You must act within the limits of your knowledge, skills and experience and when necessary, refer the matter safely to another health or social care professional.

9. References

1. The Scottish Government. (2018). *Practising Realistic Medicine: Chief Medical Officer for Scotland annual report 2016-17* [online]. Edinburgh: APS Group Scotland. Available from: https://www.gov.scot/binaries/content/documents/govscot/publications/report/2018/04/practising-realistic-medicine/documents/00534374-pdf/00534374-pdf/govscot%3Adocument

2. National Institute for Health and Care Excellence. (2021). *Shared decision-making* [online]. Available from: https://www.nice.org.uk/guidance/ng197/resources/shared-decision-making-pdf-66142087186885

3. Kahneman, D. (2012). *Thinking, Fast and Slow.* London: Penguin.

4. Flin, R., O'Connor, P., Crichton, M. (2008). *Safety at the Sharp End: A Guide to Non-Technical Skills.* Aldershot: Ashgate.

5. Vincent, C. (2010). *Patient Safety.* 2nd Ed. West Sussex: Wiley-Blackwell.

6. Scottish Public Services Ombudsman. (2017*). Informed consent: Learning from complaints* [online]. Available from: https://www.spso.org.uk/sites/spso/files/communications_material/research/Informed%20Consent%20SPSO%20March%202017%20(PDF,%20246KB).pdf

7. Resuscitation Council. (2015). The ABCDE approach. [online]. Available from: https://www.resus.org.uk/resuscitation-guidelines/abcde-approach/

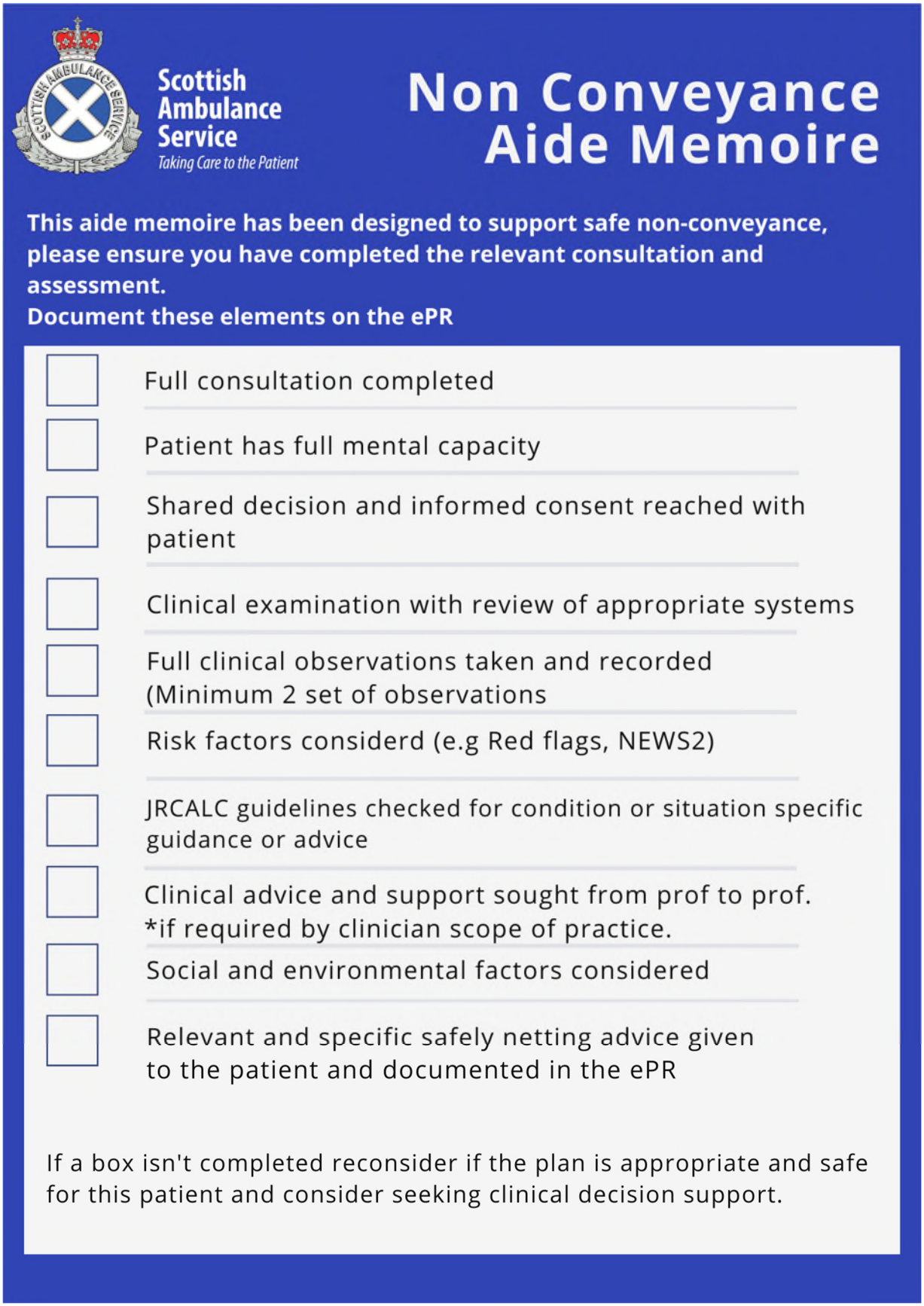
8. Silverman, J., Kurtz, S., Draper, J. (2013). *Skills for Communicating with Patients.* Florida: CRC Press.

9. Neighbour, R. (2015). *The inner consultation: how to develop an effective and intuitive consulting style.* 2nd edn. London: CRC Press.

Appendix A – Content of Calgary-Cambridge consultation guide

Section of guide	Process skills
1. Initiating the session	– Establish initial rapport. Introduce self and obtain patient's name – Identify reason(s) for the consult (should be an open question) – Listen without interruption – Summarise reason(s) for the consult – Explain what happens now
2. Gathering information	– Explore the problem(s) – Use open questions where possible (not limiting or leading) – Listen attentively – Allow the patient to complete statements without interruption – Pick up verbal and non-verbal cues – Clarify statements that are unclear – Summarise throughout to verify own understanding – Encourage patient to express feelings – Keep note-taking to a minimum during consult – Consider the psycho-social, emotional, environmental and familial considerations of the complaint(s) – SAMPLE and SOCRATES can be incorporated as required
3. Physical Examination	– Gain informed consent – Systems review as required e.g. respiratory, cardiac, neurological, abdominal, and musculoskeletal. – Further clinical observations – Maintain dignity and privacy throughout
4. Explanation and Planning	– Chunks and checks (give info in manageable chunks, always checking for understanding) – Use repetition and summarising to reinforce information – Avoid giving advice or reassurance prematurely – Avoid medical jargon (where appropriate) – Achieve a shared understanding – Provide opportunities to ask question, express doubts, discuss preferences – Involve patient by making suggestions rather than directives – Offer choices (where possible) – Negotiate a mutually acceptable plan – Share the decision-making
5. Close the Session	– Briefly summarise the session – Briefly clarify the plan of care – Final check that the patient agrees and is comfortable with the plan – Safety netting arrangements and advice when required

Appendix B: Referral or discharge checklist/aide-memoire



Appendix C: Emergency Care Summaries/Key Information Summaries (ECS/KIS)

There is the facility to access further information related to the patient via the ECS/KIS section of the electronic patient record.

All patients registered with a GP in Scotland will have an ECS record, however only around 300,000 patients have a KIS. These are generally patient with long term conditions or anticipatory care plans. A KIS is always displayed as part of the ECS, if one exists.

The information in this section can be generated by having a minimum search criteria of the patient's surname, date of birth and gender, or the Community Health Index (CHI) number.

The system will produce a list from which the SAS clinician can select the patient they are caring for. The ECS/KIS might include information related to current prescription list, allergies, GP special notes, end of care life plans and DNACPR.

Scottish Ambulance Service
Taking Care to the Patient

Non Conveyance Aide Memoire

This aide memoire has been designed to support safe non-conveyance, please ensure you have completed the relevant consultation and assessment.
Document these elements on the ePR

- [ ] Full consultation completed
- [ ] Patient has full mental capacity
- [ ] Shared decision and informed consent reached with patient
- [ ] Clinical examination with review of appropriate systems
- [ ] Full clinical observations taken and recorded (Minimum 2 set of observations
- [ ] Risk factors considerd (e.g Red flags, NEWS2)
- [ ] JRCALC guidelines checked for condition or situation specific guidance or advice
- [ ] Clinical advice and support sought from prof to prof. *if required by clinician scope of practice.
- [ ] Social and environmental factors considered
- [ ] Relevant and specific safely netting advice given to the patient and documented in the ePR

If a box isn't completed reconsider if the plan is appropriate and safe for this patient and consider seeking clinical decision support.

Scottish Ambulance Service
Taking Care to the Patient

Shared Decision Making

Key points in reaching a shared decision with patients regarding assessment, treatment and outcome options.

Making the decision

1. Establish rapport
2. Gain history / gather information including patient's wishes
3. Physical Assessment including observations and presentation specific tests
4. Consider risk factors (e.g. red flags, NEWS2, vulnerability / frailty, available services, location and time of day).
5. Explain and agree a plan
   - Provide information
   - Ensure recall and understanding for informed consent
   - Involve the patient where possible
   - Consider any factors that may influence patient participation
6. Consider seeking decision making support from suitable source
7. Close the session

CONVEY

Often, the shared decision will be for the patient to be conveyed to hospital.

Consider local guidelines and pathways for appropriate destination.

The SAS default position is that all children under age of 2 should be conveyed.

REFER

Shared decision for the patient's care transfers to another health or social care professional for consultation, review or action.

Consider local referral pathways.

Safety netting advice must be given to cover the period until follow up.

DISCHARGE

Shared decision to conclude all care on scene (no referral).

In line with clinician scope of practice.

Specific safety netting and self-care advice must be issued and documented.

Safety netting

Ideally, safety netting advice would:

- Be specific so patient knows what to look for.
- Outline time period to monitor for symptoms.
- Explain what to do to seek further help.
- Make clear that if in any doubt, don't delay seeking advice.
- Be recorded on the ePR

Points to consider:

- If I'm right what do I expect to happen?
- What happens if I'm wrong?
- What the patient needs to do.

Patient Care Record – record the following in ePR

- History taking
- Assessment
- Capacity and consent
- Observations
- Shared decision making plan
- Details of worsening advice given
- Self-care advice offered
- Referral details
- Prof to prof details

The full Clinical Decision Making framework is available on @SAS & JRCALC App