Title CSOP 001 Development and Review of SOP's

Version No: 2.4 Effective date: 24/04/2024

APPROVALS

Original Document Author:	Name Dr Neil Thomson, HEMS Doctor	Date	Signature
Revised Document Prepared by:	Justin Squires, Deputy Clinical Lead		
Reviewed by:	Philip Bridle, Head of Operations		
Approval:	Richard Clayton, Chief Operating Officer		
Next Review Date:	April 2026		

HISTORY

Effective Date	Version No.	Summary of Amendment
09/10/12	2	Review of document control
17/11/14	2.1	Review and amendment from Director to Head of Operations
Feb 2017	2.2	Review
October 2021	2.3	Addition covers development of all SOPs including clinical, operational and those relating to TCAA. Addition of annexes. Addition of publication on charity internet of CSOPs and of monitoring of crew currency with SOPs via taasBase red/green. Update of expectations of review process. Discussion of relationship with national guidelines & SOPs. Removal of Annex B as no longer required.
April 2024	2.4	Amended Director of Operations to Chief Operating Officer, added potential for use of editable live versions if significant changes required after submission for approval. Annex format revised; process unchanged.

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APPENDICES/ANNEXES

Appendix/Annexes	Title
A	CSOP Flowchart

DEFINITIONS

Acronym/ Abbreviations	Description
CSOP	Clinical Standard Operating Procedure
OSOP	Operational Standard Operating Procedure
TCAA SOP	Children's Air Ambulance Standard Operating Procedure

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1. Purpose

It is essential that The Air Ambulance Service takes a uniform approach in the way patients are assessed and treated and the way that operations are conducted. The fact that many clinicians only work occasional shifts makes it even more important that things are done in the same way, regardless of who is on the crew.

This will reduce the risk of errors and optimise patient outcomes. This document describes the procedure followed to ensure that Standard Operating Procedure's (SOP's) are developed and governed in a robust manner.

2. Introduction

2.1 The unit's medical staff frequently deal with very seriously ill or injured casualties. The circumstances surrounding the illness or injury may be highly complex and may make detailed assessment and clinical care very difficult.

2.2 It is recognised that pre-hospital medicine is constantly evolving, and that practitioners will be exposed to a wide variety of different practices and approaches to clinical conditions in their hospital or other roles.

2.3 In order to ensure a safe and consistent approach to the management of patients and situation, it is important that a set of operational procedures are devised, both in clinical and non-clinical procedures. The use of standard procedures has been shown to reduce risk and ensure safe and appropriate care.

3 Development

3.1 Any member of the team who feels a new SOP would be indicated for a specific purpose, should discuss this with one of the clinical leadership team in the first instance. Following this a new draft SOP can be developed.

3.2 SOP's should:

- Be based on evidence shown to improve patient outcome and/or reduce risk
- Incorporate national trends and guidance
- Take into account regional and local practices
- Allow a degree of flexibility to take into account specific situational variances or individual patient needs
- Not contradict other clinical or operational procedures

3.3 Authors should encourage peer-review of draft procedures. Whilst it may not be possible to seek an opinion of every clinician on the unit, advice should be taken from recognised experts in particular areas of practise.

3.4 Seeking advice or guidance from hospital specialists and other approved clinical networks will increase seamless integration of patient care.

4 SOP Structure

4.1 All SOPs must have the same structure and format.

4.2The following must be included in all SOP's:

- Title
- Target Audience
- Authors and Reviewers
- Date of Approval
- Date of Review
- Links to other operational or clinical SOPs
- Appendices such as drug doses or age ranges
- References and Standards

5 Process Flow

All SOP's should be sent directly to the operations support officer by the reviser who will then distribute to the named reviewers. All reviewers should return to operations support officer with

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any comments or tracked changes to the documents. Any comments or changes will be sent back to the reviser by the operations support officer. Once all parties are in agreement the SOP will be sent to the Head of Operations for review of all comments before going for final review to the approver, Chief Operating Officer for Operational SOPs / Clinical Lead or nominated deputy for Clinical SOPs.

The document sent for approval should have all changes accepted, and be correctly formatted and cleaned ready for publication if agreed.

The standard process is set out in Annex A and must be followed to ensure versions are controlled.

Should a document require significant changes at the approval stage an editable live version of the document can be set up and changes managed through a discussion group of revisers and reviewers as needed.

6 Document Control

6.1 All SOPs are subject to Document Control
6.2 Document ownership rests with the Chief Operating Officer or the Clinical Lead.
6.3 All SOPs should be numbered and dated
6.4 A .pdf version will be available on a secure section of the Charity Intranet site.
6.5 Only secure .pdf files should be distributed electronically and marked uncontrolled. Editable versions are not to be distributed unless marked DRAFT for review purposes.
6.6 CSOPs may be shared with other emergency services and receiving hospitals to ensure that they are conversant with the range of interventions and procedures (and the associated evidence base) that may be used by the unit's clinical personnel. All such distributions of SOPs should be marked NOT DOCUMENT CONTROLLED ONCE PRINTED.
6.7 CSOPs will be automatically added at the approval of their next revision to a public area of the charity website, with an appropriate legal use disclaimer. Any sensitive information (such as phone numbers etc) will be removed from CSOPs by the approver prior to publication on the internet and this will be stored in a file on the CSOP section of sharepoint. If a CSOP is considered unsuitable for public access for any reason, this will be specified to the Operations Support Officer by the approver.
6.8 OSOPs and TCAA SOPs may be shared with other outside agencies if deemed relevant. All such distributions of SOPs should be marked NOT DOCUMENT CONTROLLED ONCE PRINTED.

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7 Review

7.1 All SOPs are subject to regular review and must have a review date set.
7.2 The review date should be no longer than 2 years after the issue date.
7.3 Reviewers are required to expedite reviews as quickly as possible to ensure compliance to set review periods. Compliance will be monitored at monthly Operations Teams Meetings and quarterly Clinical Governance Group meetings.
7.4 Early review of a procedure should take place if new evidence comes to light, or in keeping with national and regional trends. The review process must include a new literature search and update of references / addition of new relevant information.
7.5 Information which has become common knowledge as knowledge advances over time or which is readily available via the internet, should be left as a hyperlink and not repeated verbatim in a SOP.
7.6 Large sections of national guidance should not be extracted and repeated in SOPs, these should be referenced. Guidance should be provided in SOPs as to how we meet relevant national / international guidelines, what equipment we use and in what ways we may differ from them due to our specific operational circumstances that they may not be designed to cover.

8 Adherence & Compliance

8.1 All clinicians are expected to be fully conversant with the contents of all clinical and operational procedures. New revisions of SOPs and new SOPs will be issued via the red/green system on taasBase which can be used to manage currency. TCAA SOPs and any Operational SOPs that are relevant to TCAA staff are sent to them via the red/green system on taasBase.
8.2 It is recognised that operational procedures cannot take into account all the variables that may be encountered on a particular scene or incident. However, clinicians will be expected to explain and fully justify their actions should they choose to divert from standard policy.
8.3 Where adherence to a policy or part of a policy is mandatory, this must be clearly stated.
8.4 (MANDATORY) Knowledge and understanding of an SOP does not equate to the right to practise the skill or procedure detailed in the SOP. It is the responsibility of the individual clinician to work within their scope of practice and to their level of competency.
8.5 (MANDATORY) In all cases prescription-only medications are only to be administered by or under the direct supervision of a doctor unless they fall within the POMs exemptions applying to Paramedics or a Patient Group Direction.

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