LONDON'S AIR AMBULANCE
roadside intensive care

Pre-hospital Care Standard Operating Procedure

Packaging

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APPROVAL/ ADOPTED:	PHC Policy Board	
DISTRIBUTION:	PHC Doctors PHC Paramedics	
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THIS DOCUMENT REFERS TO:	☑ PHC Clinical Practice PHC Non-clinical Practice PHC Operational Procedure	Ref: CP-11

Aims:

- Describes how patients should be packaged for transportation.

Background:

Packaging is not simply a means of getting a patient to hospital it should be seen as a fundamental part of the therapeutic process. The packaging procedure aims to:

- Minimise spinal movements.
- Minimise clot disturbance and repeated blood loss.
- Minimise cytokine release.
- Maintain normothermia.

In an attempt to minimise clot disruption, a log roll may not be required in a polytrauma patient. Similarly, the patient with a presumed spinal injury should not be moved more than necessary and may not require a log roll. Remember that they will have extensive imaging at hospital and a clinical examination of the back is often unnecessary.

Policy:

- Severely injured patients should be packaged “skin to scoop”.
- Spinal boards are for extrication only, not packaging and transportation.
- Take time to cut the clothes correctly - it will make things run far more smoothly.
- Depending on the mode of transport the orthopaedic scoop stretcher should then be placed either on a trolley bed for ground transfers or the vacuum mattress for airlifting.
- We aim to deliver normothermic patients to hospital except when therapeutic hypothermia has been specifically induced.

1. Patients found prone or in the lateral position

- Carry out the initial stages of the assessment in this position.
- Unless the patient's airway is obstructed/ apnoeic leave the patient prone and apply an oxygen mask.
- Cut the clothes at the back from top to bottom all layers. Clothes can be cut in a Y shape, vertically down the midline of the back and then down both legs.
- Draw the scoop out to length and split. Place one half on the ground ready to roll the patient on to it. (For prone patients consider not splitting the scoop).
- With the patient prone assess the chest, spine and pelvis. If the mechanism or clinical examination suggests a fractured pelvis, a pelvic splint should be placed on top of the scoop blade. Take time to get positioning correct - you don't want to have to move the patient again.
- When the scoop +/- pelvic splint are in place roll the patient in a controlled manner. Roll to 90° and place the scoop against the patient. Stop here and change hand positions for the rest of the roll to horizontal. The patient should now be on half a scoop blade, skin to scoop.
- Next a small 10° roll should allow you to place the scoop in position – again ensure it is next to skin.
- With the scoop secured (top and bottom) the patient can be placed on a trolley bed or in the vacuum mattress.
- To prevent lateral shift of the spine and stabilise the patient on the vacumat blankets may be placed against the sides of the patient.

2. Patients found supine

- Ensure the airway is patent and oxygen is in place.
- Clothes should be cut up the sides to facilitate exposure. This includes the arms.
- If there is no requirement to examine the back of the patient, two 10^{o} rolls will allow insertion of separated scoop blades between the patient's skin and the cut clothes.
- If there is a need to examine the back, the patient can be rolled to 90° to assess the back and place the patient skin to scoop on the first side. The second roll can be 10° to place the second scoop blade.
- With the scoop secured (top and bottom) the patient can be placed on a trolley bed or in the vacuum mattress.

3. LAS packaged

- You may come across patients who have been completely packaged and are securely fixed to a spinal board. On these occasions it may be acceptable to leave the patient on the board depending on the clinical state. Usually, this applies if there is no further examination needed and the patient is considered well enough for a ground assist.

4. Extricated on a spinal board

- If a patient is extricated from a car on a spinal board then the initial resuscitation should take place on the board and the patient then packaged as if 'found supine'.

5. Head Injuries

- Once packaged on the scoop stretcher and in position for transport, with blocks and tape in place, the cervical collar should be loosened but left in-situ in order to limit raised intra-cranial pressure due to venous obstruction.
- If the patient is to be moved or transferred at all, the collar can be re-secured.
- It is also advisable to give these patients a slight head-up tilt (20^{o}) if possible to assist venous drainage.

6. Vertical Lift

- Patients who require a vertical lift should be packaged with appropriate equipment that e.g. Neil Robertson stretcher which is provided by the fire service or the HEMS Chrysalis stretcher

- It should be recognised that the scoop/ vacuum combination and a spinal board do not offer total support in the longitudinal plane i.e. the patient in theory could fall out the bottom / top if moved into vertical position. Take care in ensuring all straps are as tight as possible.

7. Handover

- It is the responsibility of Medic 1 to ensure the receiving team remove the patient from the scoop in a controlled manner. This means removing the scoop by traction and counter traction, not a full log roll.
- If a log roll has been done on scene ensure the team know the clinical findings of the back ie wounds or deformity.
- If a log roll was not performed, make that clear on handover.
- Document the findings of the back examination in the notes.