LONDON'S AIR AMBULANCE roadside intensive care

Pre-hospital Care Standard Operating Procedure

Triage

REVIEW:	May 2010	
APPROVAL/ ADOPTED:	PHC Policy Board	
DISTRIBUTION:	PHC Doctors PHC Paramedics	
RELATED DOCUMENTS:	SOP Burns SOP Penetrating trauma SOP Thoracotomy	
THIS DOCUMENT REFERS TO:	☑ PHC Clinical Practice PHC Non-clinical Practice PHC Operational Procedure	Ref: CP-15

Aims:

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- Describe triage process
- Describe “blue calls” (alerting call to receiving A&E).
- Describe policy for “refusal of treatment”
- Describe classification of HEMS calls

Background:

It is important to ensure patients are taken to the correct hospital in the first instance. Secondary transfers from local hospitals to tertiary centres are well recognised as a source of increased mortality and morbidity.

There is a “triage software programme” in HEMS Operations which generates a printout of available hospital resources for each incident. Details include local hospital contact numbers, specialist facilities and distances from the incident. This printout should be taken on every mission and is brought to the aircraft by the co-pilot.

It is a simple programme based on the A to Z map book. Distances on the printout are measured as “the crow flies” in nautical miles. The programme assumes that the incident has occurred in the middle of a grid square, which may not be the case and therefore may give slightly misleading information. **Always** ask the ambulance crew which hospital they would normally take the patient to as this utilises their local knowledge.

Patients should be taken to a hospital with appropriate facilities. Where possible triage decisions should mimic the likely tertiary referral patterns however it is recognised that several factors such as local traffic conditions, the presence of landing facilities at the receiving unit and the fragility of the patient to under take secondary transfer may alter flows.

Over-triage is inevitable – mechanism of injury is a sensitive but not specific marker of severe injury. It is also the very nature of the disease that more injuries declare themselves with time.

Policy:

- Do not rush into a triage decision. There is often pressure from other Emergency personnel to produce an early decision. Avoid premature decisions as you may appear indecisive and lose the confidence of others. However, if you are at all concerned do not be afraid to upgrade your decision to move to a tertiary centre, it may annoy your colleagues but the patient's best interest is more important. Explain your reason for upgrading, as this will help everyone understand the rationale.

- Your decision must take into account the patient's clinical needs, the level / specialty of hospital and the method of transportation. You should take advice from the local crew, the HEMS crew members and the triage printout from ops. EOC may help to clarify distances or specialist facility information if this is in doubt. If necessary, call the PHC Consultant to help you with the decision.

- When considering journey time to hospital, remember that in addition to flight time there is an additional on & off load time associated with aircraft carry backs. A land based journey of fifteen minutes or less is quicker than loading a patient for a short flight. Any land based journey of more than twenty minutes is well worth considering using the aircraft.

- Remember that at present RLH is the only hospital where it is possible to land without requiring an ambulance for a transfer to the Emergency Department. Hence, it is unusual for any patient to be flown to another London hospital.

- Always consult the pilots regarding your triage decision. It may be sunny where you are but where you want to land, weather may be inclement. Avoid an IFR flight (instruments) at all costs when dealing with patients in the primary role.

- Inform EOC of your decision, as this will allow them to make any other arrangements [e.g. an ambulance to pick you up when you land in a nearby park].

- For information regarding the triage of burns and penetrating trauma patients, refer to the specific SOPs.

Alerting the Receiving Unit

Let the receiving hospital know your decision via the "blue phone" number programmed into the mobile phone. Make the 'blue call' 10 minutes before arrival at hospital. Always clarify to whom you are speaking ie senior nurse… not a receptionist.

Clearly state:

- Your name and position.
- Patient injuries, GCS, and treatment to date.
- Whether the patient is ventilated or not
- Indicate whether you need specific surgical back up and any other resources e.g. blood / massive transfusion pack (CODE RED @ RLH) / cardiopulmonary bypass.
- Remember cardiothoracic surgeons are rarely a regular part of a trauma team. If you think the patient requires their input request their presence at this point.
- Mode of arrival – air or land
- ETA

If you are travelling to a hospital by land inform the crew that you will make the blue call, otherwise they will automatically do this. The hospital will presume they are to receive 2 patients!

There is no such thing as a "courtesy call" to a hospital on the blue phone. Any activation via the blue phone system by HEMS will invoke a trauma team response. If the team is there waiting for an uninjured patient it makes the service look inept. If you intend to ground assist let the normal course of events take place.

Refusal of Treatment

On rare occasions patients attended by HEMS will refuse aid. Every individual has the right to exercise this decision. Under these circumstances the consequences should be made clear to the patient in a non-confrontational manner.

Doctors & paramedics should familiarise themselves with "The Mental Capacity Act" and the implications of this act for prehospital practice.

If possible the patient should sign the HEMS notes pertaining to the mission, to the effect that, "the consequences of non treatment have been explained and that he / she willingly refuses all aid". If the patient refuses to do this the events should be documented by the HEMS registrar and witnessed by the flight paramedic.

It is important to remember that there are still interventions or advice that the patient may still be given.

On occasions where the competence of the individual to make such a decision is doubted eg hypoxia / hypovolaemia / serious injury / intoxication etc then the doctor should contact the PHC consultant by air call, indicating that urgent telephone advice is needed on scene with the appropriate contact number.

Classification of calls

HEMS missions are recorded on the database according to the following groups.

- **A Group - Missions where the HEMS doctor accompanies the patient from the scene**
  A1 to Royal London by air
  A2 to Royal London by road
  A3 to other hospital by air
  A4 to other hospital by road

- **B Group - Missions where HEMS doctor accompanies patient from one hospital to another**
  B1 to RLH
  B2 to other hospital

- **C Group - Missions where HEMS doctor does not accompany the patient**
  C1 to other hospital
  C2 dead

- **D Group - Aborted missions**