

Transfer patient to the proper health center



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1. Concept and purpose of the transfer of patients

Between pre-hospital and hospital assistance there is a transition space: the ambulance that perform the patient's transference. A transfer is defined as:

“Communication between health professionals in which a patient's clinical information is transmitted and the responsibility of care to another health professional or group of professionals, either temporarily (relay, shift change) or permanent (unit change is transferred or level of care).”

The ultimate purpose of the transfer is the transfer of both the patient and the patient's clinical information and ensure compliance with the therapeutic objectives in the context of safe care in which continuity of care is not interrupted.

When taking a booking for a patient transfer, we follow the Interfacility Patient transfer standard. This is a guide to assist matching staff clinical level to patients clinical requirement.

in Ireland for example, Murray Ambulance Service Ltd, will engage with their clients in a courteous manner at all times having regard to the Equal Status Act 2009, as well as relevant civil law. Clients contact with MAS may be in person, electronic or most usually, by telephone.

Certain data is required by MAS in relation to client's personal information in order to effectively and efficiently serve our clients.

We undertake to do this in a sensitive and confidential fashion, having regard to the emotional situation of people when a family member is unwell.

MAS will use that data only for the purpose for which it is intended, namely service provision and billing the insurance company after the fact.

MAS staff will maintain confidentiality in respect of information received and hold it securely.

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Electronic storage of such data will be enhanced by firewalls and by securing premises where data is stored when not manned.

The minimum data set required by MAS may vary from client to client or depending on legislation or statutory requirements of organisations, such as PHECC.

Dispatch managers will record client and journey detail as outlined on the calls management system in use at any given time. No extraneous information will be recorded unless directly related to the client's health, their journey or billing mechanism.

If there are situations where it is not clear that MAS can fulfil a commission the dispatch manager must consult or follow PHECC parameters for delivery of care so as to ensure safe practice.

2. Clinical safety

Patient safety, also called clinical safety, is a component of health care that guarantees the quality of care provided. All actions related to health care must meet the principle of do no harm: *primum non nocere*.

Concrete actions as hospital transfer are not without mistakes, being the most common derivatives of communication between professionals.

Responsibility for identifying clinical risk rests with every member of Murray Ambulance Service staff, once identified and notified to management the risk implementation goes to the medical director and the Paramedic Tutor for assessment of the risk and the planning of remedial actions as well as the collation of findings in order to negate or minimise future risk.

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All staff have a statutory requirement to take care as far as is possible of their health and safety and that of others who may be affected by their acts or omissions at work. Staff must act in accordance with training and instruction provided by Murray Ambulance Service.

Staff must use all machinery, equipment, dangerous substances, means of production, transport equipment and safety devices in accordance with any relevant training and instruction provided by MAS and inform employers of dangerous situations and short comings in the health and safety arrangements of the organisation. This can be achieved by using the incident reporting procedure.

2.1. Purpose

The purpose of the Board of Management (Risk Management Board) is to have overall responsibility for establishing a strategic approach to risk management across the organisation, ensuring that the approach is pro-active. The Board is also responsible for the overall co-ordination of risk management activity. It ensures that the necessary processes are in place to achieve compliance with statutory requirements and to protect the Trusts' patients, staff and assets. Risk management will be an integral part of MAS strategic and operational objectives.

2.2. Duties

- Agree, monitor and ratify MAS risk management strategy and policies. The Board will decide on all policies approved ensuring the policies are implemented effectively, reviewed, updated and approved
- Assist the staff in defining acceptable risk within the organisation
- Ensure that adequate organisational systems are in place for implementing controls assurance
- Make recommendations on priority risk areas and appropriate action required

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- Oversee identification and implementation of the risk management action plan and risk registers
- Review all directorate risk registers
- Review and approve the “accepted” risk registers
- Receive information on incidents and their analysis and assess trends and developments and make recommendations on appropriate improvements
- Prepare an annual progress report for the Board at the end of each financial year
- Review the Risk Management Strategy on an annual basis
- Ensure that all requirements are met for the Managing Director to sign the annual Statement of Internal Control
- To be informed of any serious untoward incidents and ensure that follow up actions plans are developed, implemented and monitored
- To be informed of external visits, assessments or requests for information by members of inspection bodies, audit bodies or other external agencies.

2.3. Infection Control of Patients

All crew members should follow strict infection control procedures and have ready access to hand hygiene facilities on board their ambulance.

When taking a booking for a patient transfer control staff must enquire if there any infection control issues.

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3. Verbal and documented transfer

The transfer means, therefore, several tasks:

- Transfer the patient to the receiving center.
- Verbal transmission of information, neat and about the attention, status and patient outcome.
- Transfer any information of interest about the accident: injury mechanism, deformities in vehicles, etc.. (we are the eyes of the hospital in this sort of thing).
- Transfer of the clinical history generated, healthcare report. In general, it is in carbonless copy paper, to have at least one copy for the hospital and other services for our file.
- Transfer of personal belongings of the patient for safekeeping.
- Patient registration in the service reception center admission (admission sealing on the copy for our service). Each performance will be identified with a serial number that correspond to the number assigned by the coordinating center or department responsible for recording every care in a database. These data, which are assigned automatically, interact directly with the event data and patient identification.

In Ireland, as per the inter facility patient transfer standard depending on the clinical level the patients requirement is i.e 1 Paramedic and 1 Emergency Medical Technician on the ambulance. The Paramedic would hold the clinical lead of the patient.

In Ireland when a crew pick up a patient from a referring facility they must take a baseline assessment (handover) of the patients details and current medical condition. As part of our accreditation process Murray Ambulance Service designed an inter hospital standard document. This is used to take a baseline assessment of the patient to ensure the patient is able to be transferred. A Patient Care Report form (PCR) is also filled out by the crew member throughout the journey, ensuring regular checks are made of the patient thus ensuring safe standards. This can be done both by hard copy or by an android Tablet. This information goes to a secure database.

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Patient Care Report forms when generated become part of the patients health history and as such should be valued as much as any other patient record completed by other health professionals. The PRF is evidence that patients have been treated efficiently and effectively and should also record their response to treatment.

3.1. Standards for the transfer process

For the proper development of the transfer, it is convenient to structure the transmission of information: what is going to tell and in which order, status, background and recommendations. After several research, a hospital team proposes to adopt the mnemonic ISOBAR:

I. Identification: identification of professionals responsible for assisting the patient.

S. Status: source of health care, changes in the patient's condition, possible complications and ways to monitor.

O. Observation: recent vital signs, performed tests, patient assessment.

B. Background or relevant medical history: risks and allergies.

A. Agree on a plan given the situation:

- What to do to normalize it?
- What has been done? (treatment, therapeutic measures, care...).
- What is pending? (therapeutic measures, medication infusions, checks).

R. Read-back: confirm the effectiveness of the transfer and establish responsibilities (who does what and when).



As above, a Patient Care Report form is filled out throughout the journey of the patient.

These are the recommendations to minimize the risks of transfer:

- The transfer should be an orderly and systematic process carried out in the presence of the patient, encouraging their involvement and verification.

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- If impaired perception (low level of consciousness, neurological disorders) should be done in the presence of a relative or close friend.
- The transfer must be in a critical area or very close to it, in which there are resources to ensure patient monitoring and emergent care in case of deterioration of the patient's condition.
- The transfer must be done in a place where you can preserve patient privacy and confidentiality of the information provided, step away from other professionals and bystanders outside assistance, free from noise and / or interruptions that difficult the communication.
- The transferred information must be accurate and relevant obviating unnecessary details that prolong the process and divert the attention of the relevant information.
- The language used should be clear and standardized, clarifying terms that may be ambiguous. It is inappropriate to use colloquialisms or include personal interpretations of the patient's clinical situation.
- The transmission of information verbally enhances communication and given the opportunity to ask clarifying questions receiver.
- The documented record of care provided (paper or computer) is the tool to check off and expand the information transmitted.
- If registration is manuscript must be legible and not recommended abbreviations.
- The time spent should be sufficient to include the opportunity to ask questions and answer them. We recommend using feedback techniques and read-back to ensure the accuracy of the information.

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3.2. Children and vulnerable adults as patients of the ambulance

Murray Ambulance Service has created the following policy pertaining to the transportation of children and vulnerable adults in our vehicles.

Scope

For the purposes of this policy the following definitions apply:

- A child means a person under the age of 18 years, [Children’s Act 2001].
- A vulnerable adult is a person over the age of 18 years who has a physical, sensory or cognitive deficit, which may prevent them protecting themselves, expressing their needs or thoughts effectively or advocating in their own interests. (Poelenjee, E. 2012, Murray Ambulance Service)
- When our services are engaged to transport a child or vulnerable adult the Proprietor, or their appointee, will assign a crew to transport that person. The Proprietor or their appointee, will, through a series of questions,(see addendum below), determine whether a family member or guardian or professional carer should accompany that individual.
- Where the individual to be transported is a child, a parent or legal guardian, will be offered the opportunity to accompany the child in all cases except where there are medical or other personnel essential to the individuals care occupying all available seating in the ambulance.
- All employees of Murray Ambulance Service have a moral and legal obligation to meet the needs of the individuals in their care in a responsible fashion, particularly those clients who are children or vulnerable adults. If any employee of Murray Ambulance Service requires clarification in this specific area they should, in all cases, make contact with the Proprietor or their appointee, to ensure the highest standard of care possible is delivered.

Addendum

- Where a child or vulnerable adult is to be transported by Murray Ambulance Service the clerical officer should ask the following questions:
- Is a parent or guardian travelling with the child? Encourage a parent or guardian to travel.
- Is this a vulnerable adult?
- If so is there anyone travelling with the client? Encourage a family or professional carer to accompany them.
- Is there any issue with the communications skills of that person?
- If so encourage someone who knows the client well to accompany the client.
- Is the client suffering from a physical or other deficit that would prevent them being able to advocate in their own interest? If yes try to arrange that someone who can act as advocate for the client accompany them.
- Where the client is resident in long term care it is advisable that someone they are familiar with accompany them so as to allay any trepidation or anxiety they may have in relation to the journey or medical care they are travelling to receive.

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4. Types of reports of medical assistance

The attendance report is the standard document used by each service, created to transmit clinical information necessary to transfer the patient, and continue to focus on the center of target.

4. Types of reports of medical assistance

PATIENT CARE REPORT	
PATIENT INFORMATION	
SURNAME	FIRST NAME
PERMANENT ADDRESS	
DOB	AGE
GENDER	
GP	NOK TELEPHONE
NEXT OF KIN	
INCIDENT INFORMATION	
DATE OF CALL	TIME OF CALL
DISPATCH CLASSIFICATION	
MOBILE	AT SCENE
AT PATIENT	DEPART SCENE
AT HANDOVER	DESTINATION
NAME OF FACILITY	
CC	VEHICLE
PRACTITIONER ATTEND	
PRACTITIONER SUPPORT	
OTHER	
STATION PIN	
TCD	
NIT	
Incident Location/Address	
Nature of Assistance Prior to Arrival of Practitioner	
Identity of Assistance Prior to Arrival of Practitioner	
CLINICAL LEVEL	
PRACTITIONER OFF DUTY	
DOCTOR	

CLINICAL INFORMATION		
PATIENT'S CHIEF COMPLAINT	TIME OF ONSET DATE OF ONSET	
PRIMARY SURVEY		
A		
B		
C		
D		
E		
CLINICAL IMPRESSION		
CARDIAC	OBSC/GYN/AE	MAXILLO-FACIAL INJURY
MEDICAL	RESPIRATORY	GENERAL
NEUROLOGICAL	TRAUMA	

CLINICAL INFORMATION	
PATIENT'S MEDICAL OBSERVATIONS	
A	
M	
P	
L	
E	
MECHANISM OF INJURY	
CIRCUMSTANCES	

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Pre-Hospital Emergency Care Council		PATIENT CARE REPORT	
PATIENT INFORMATION			
SURNAME		FIRST NAME	
PERMANENT ADDRESS		DOB	
AGE		GENDER	
GP			
NEXT OF KIN		NOK TELEPHONE	
INCIDENT INFORMATION			
DATE OF CALL	TIME OF CALL	PASSED	DISPATCH CLASSIFICATION
EMERGENCY	01	02	03
MOBILE	AT SCENE	AT PATIENT	DEPART SCENE
AT HANDOVER	DESTINATION	CLEAR	
CC			
PRACTITIONER ATTEND	PRACTITIONER SUPPORT	OTHER	STATION PIN
TCD	DOA TRANSPORTED	DIED AT SCENE/ENROUTE	
NTT	TREATMENT REFUSED	TREAT AT SCENE - NO TRANS.	
Incident Location/Address <input type="checkbox"/> Mark it same as Above			
HOME	IND. PLACE OR PREMISES	PUBLIC BUILDING	
FARM	RECR. OR SPORT PLACE	RESIDENTIAL INSTITUTION	
MINE OR QUARRY	STREET OR ROAD	OTHER PLACES	
Nature of Assistance Prior to Arrival of Practitioner			
NONE	FIRST AID	CPR*	
AED*	ALS	* Refer to OHCA Section Over	
Identity of Assistance Prior to Arrival of Practitioner			
VOLUNTARY / AUXILIARY	FIRE	OTHER	
GARDA			
CLINICAL LEVEL			
NO TRAINING	CPR		
OFA	EFR		
PRACTITIONER OFF DUTY	NURSE		
DOCTOR			

CLINICAL INFORMATION		
PATIENT'S CHIEF COMPLAINT		
TIME OF ONSET DATE OF ONSET		
PRIMARY SURVEY		
A <input type="checkbox"/> CLEAR <input type="checkbox"/> PARTIALLY OBSTRUCTED <input type="checkbox"/> OBSTRUCTED		
C <input type="checkbox"/> Spine <input type="checkbox"/> SUSPECT <input type="checkbox"/> NOT INDICATED		
B <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> FAST <input type="checkbox"/> SLOW <input type="checkbox"/> ABSENT		
C <input type="checkbox"/> PULSE <input type="checkbox"/> PRESENT <input type="checkbox"/> ABSENT <input type="checkbox"/> RATE <input type="checkbox"/> HATE <input type="checkbox"/> HAEMORRHAGE <input type="checkbox"/> Yes <input type="checkbox"/> No		
SKIN <input type="checkbox"/> NORMAL <input type="checkbox"/> PALE <input type="checkbox"/> FLUSHED <input type="checkbox"/> CYANOSED		
Cap-Refill <input type="checkbox"/> < 2 SEC <input type="checkbox"/> > 2 SEC		
D Loss of Consciousness Before Arrival Yes <input type="checkbox"/> No <input type="checkbox"/> AVPU		
E		
<input type="checkbox"/> A Abrasion	<input type="checkbox"/> P Pain	
<input type="checkbox"/> B Burn	<input type="checkbox"/> R Rash	
<input type="checkbox"/> C Contusion	<input type="checkbox"/> S Swelling	
<input type="checkbox"/> D Dislocation	<input type="checkbox"/> N Numbness	
<input type="checkbox"/> F Fracture	<input type="checkbox"/> W Wound	
% BURN		
CLINICAL IMPRESSION		
CARDIAC	OBS/GYNAE	MAXILLO-FACIAL INJURY
<input type="checkbox"/> CARDIAC ARREST	<input type="checkbox"/> HAEMORRHAGE < 20 WWS	<input type="checkbox"/> FRACTURE
<input type="checkbox"/> CARDIAC ARRHYTHMIA	<input type="checkbox"/> HAEMORRHAGE > 20 WWS	<input type="checkbox"/> DISLOCATION / SPRAIN
<input type="checkbox"/> HEART FAILURE	<input type="checkbox"/> LABOUR	<input type="checkbox"/> OPEN WOUND
<input type="checkbox"/> CARDIAC CHEST PAIN	<input type="checkbox"/> PRE-HOSPITAL DELIVERY	<input type="checkbox"/> HAEMORRHAGE
<input type="checkbox"/> OTHER CARDIAC	<input type="checkbox"/> PPH	<input type="checkbox"/> BURNS
MEDICAL	OTHER OBS/GYNAE	OTHER TRAUMA
<input type="checkbox"/> BACK PAIN	RESPIRATORY	GENERAL
<input type="checkbox"/> DIABETES MELLITUS	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> ABDOMINAL PAIN
<input type="checkbox"/> FEVER	<input type="checkbox"/> COPD	<input type="checkbox"/> ACUTE INTOXICATION
<input type="checkbox"/> HEADACHE	<input type="checkbox"/> FBAD	<input type="checkbox"/> ALLERGIC REACTION
<input type="checkbox"/> HYPOTHERMIA	<input type="checkbox"/> RESPIRATORY ARREST	<input type="checkbox"/> BEHAVIOURAL DISORDER
<input type="checkbox"/> OTHER MEDICAL	<input type="checkbox"/> SMOKE INHALATION	<input type="checkbox"/> ILLNESS UNKNOWN
NEUROLOGICAL	OTHER RESPIRATORY	<input type="checkbox"/> NAUSEA / VOMITING
<input type="checkbox"/> ALTERED LOC	TRAUMA	<input type="checkbox"/> POISONING
<input type="checkbox"/> CVA	<input type="checkbox"/> MULTIPLE TRAUMA	<input type="checkbox"/> SHOCK
<input type="checkbox"/> SEIZURES	<input type="checkbox"/> SPINAL INJURY	<input type="checkbox"/> SYNCOPÉ / COLLAPSE
<input type="checkbox"/> OTHER NEUROLOGICAL	<input type="checkbox"/> HEAD INJURY	<input type="checkbox"/> OTHER GENERAL

CLINICAL INFORMATION	
PATIENT'S MEDICAL OBSERVATIONS	
A ALLERGIES <input type="checkbox"/> NKA <input type="checkbox"/> UNKNOWN	
M MEDICATIONS <input type="checkbox"/> NONE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> AS SUPPLIED <input type="checkbox"/> PER DR'S LETTER	
P PAST MEDICAL HISTORY <input type="checkbox"/> NONE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> PER DR'S LETTER	
L LAST INTAKE <input type="checkbox"/> UNKNOWN	
E EVENT	
MECHANISM OF INJURY	
<input type="checkbox"/> ASSAULT	<input type="checkbox"/> RITA BICYCLE
<input type="checkbox"/> ATTACK/BITE BY ANIMAL/INSECT	<input type="checkbox"/> RITA MOTORBIKE
<input type="checkbox"/> CHEMICAL POISONING	<input type="checkbox"/> RITA PEDESTRIAN
<input type="checkbox"/> DROWNING	<input type="checkbox"/> RITA VEHICLE
<input type="checkbox"/> ELECTROCUTION	<input type="checkbox"/> SMOKE, FIRE AND FLAMES
<input type="checkbox"/> EXCESSIVE COLD	<input type="checkbox"/> WATER TRANSPORT ACCIDENT
<input type="checkbox"/> EXCESSIVE HEAT	<input type="checkbox"/> OTHER
<input type="checkbox"/> FALL	
<input type="checkbox"/> FIREARM INJURY	
<input type="checkbox"/> INJURY TO CHILD	
<input type="checkbox"/> MACHINERY ACCIDENTS	
<input type="checkbox"/> MVA OFF ROAD	
CIRCUMSTANCES	
<input type="checkbox"/> ACCIDENT	<input type="checkbox"/> EVENT OF UNDETERMINED INTENT
<input type="checkbox"/> INTENTIONAL SELF HARM	
↓ Impact X Pos. in Vehicle # Pos. after Acc. <input type="checkbox"/> Seatbelt <input type="checkbox"/> Trapped <input type="checkbox"/> Air Bag Deployed <input type="checkbox"/> Rollover <input type="checkbox"/> > 20 Min. Extract. <input type="checkbox"/> Fatality in Vehicle Est. speed at impact kph	

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VITAL OBSERVATION SHEET			
OBSERVATION TIMES	TIME (1)	TIME (2)	TIME (3)
PULSE RATE & RHYTHM R:Regular F:Irregular			
ECG RATE			
ECG RHYTHM			
RESPIRATORY RATE			
RESPIRATORY QUALITY 1:Normal 2:Laboured 3:Shallow 4:Wheezes 5:Rales 6:Retract 7:Absent			
%SaO ₂			
%ETCO ₂			
CAP-REFILL			
BLOOD PRESSURE	Systolic		
	Diastolic		
TEMPERATURE °C			
PUPILS Size: Reactors +Reacts -No C: Eyes Closed	L		
	R		
Pupil Size Chart			
GLASGOW COMA SCALE	EYE 4:Spontaneous 3:To voice 2:To pain 1:None VERBAL 5:Orientated 4:Confused 3:Words 2:Incomprehensible 1:None MOTOR 6:Obey 5:Local pain 4:Flex to pain 3:Abduct. 2:Ext. to pain 1:None TOTAL GCS		
PAIN SCORE 0 to 10			
BLOOD GLUCOSE LEVEL mmol/L			
ROUTE			
ORAL	PO	INTRAMUSCULAR	IM
INHALATION	INH	SUBCUTANEOUS	SC
SUBLINGUAL	SL	INTRAVENOUS	IV
BUCCAL	BU	INTRASKELETAL	IS
ENDOTRACHEAL TUBE	ETT	PER RECTUM	PR

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MEDICAL TREATMENT INFORMATION				
TIME (24H)	MEDICATION TREATMENT			
	DOSE	ROUTE	CODE (see list)	PIN
TIME (24H)	MEDICATION TREATMENT			
	DOSE	ROUTE	CODE (see list)	PIN
TIME (24H)	MEDICATION TREATMENT			
	DOSE	ROUTE	CODE (see list)	PIN
TIME (24H)	MEDICATION TREATMENT			
	DOSE	ROUTE	CODE (see list)	PIN
TIME (24H)	MEDICATION TREATMENT			
	DOSE	ROUTE	CODE (see list)	PIN

MEDICATION TREATMENT			
ADENOSINE	AD	IBUPROFEN	IB
AMIODARONE	AM	LIDOCAINE	LI
ASPIRIN	AS	LORAZEPAM	LO
ATROPINE	AT	MAGNESIUM	MG
BENZYLPIPECILLIN	BZ	MORPHINE	MO
CLOPIDOGREL	CP	MIDAZOLAM	MD
CYCLOZINE	CZ	NALOXONE	NX
DEXTROROSE 10%	DX	NIFEDIPINE	NF
DIAZEPAM	DI	NITROUS OXIDE 50% & OXYGEN 50%	NO
EPINEPHRINE (1:1 000)	EPI	OXYGEN	O ₂
EPINEPHRINE (1:10 000)	EPI10	PARACETAMOL	PA
FRUSEMIDE	FR	SALBUTAMOL	SA
GLUCAGON	GL	SODIUM BICARBONATE	SB
GLUCOSE GEL	GG	SODIUM CHLORIDE 0.9%	SO
GTN	GTN	SYNTHETINE	SY
HALOPERIDOL	HL	TENECTEPLASE	TE
HARTMANN'S SOLUTION	HS	TETRAICAIN	TR
HEPARIN	HE	DRUG PRESCRIBED BY DOCTOR	DP
HYDROCORTISONE	HC		

CARE MANAGEMENT	
AIRWAY / BREATHING	CIRCULATION SUPPORT
<input type="checkbox"/> MANOEUVRE	<input type="checkbox"/> HAEMORRHAGE CONTROL
<input type="checkbox"/> SUCTION	<input type="checkbox"/> INTRAVENOUS CANNULA
<input type="checkbox"/> MANUAL FB CLEARANCE	<input type="checkbox"/> INTRASCHEGUS CANNULA
<input type="checkbox"/> OPA / NPA	IMMOBILISATION / EXTRICATION
<input type="checkbox"/> LMALT	<input type="checkbox"/> CERVICAL COLLAR
<input type="checkbox"/> POCKET MASK	<input type="checkbox"/> SPINAL BOARD
<input type="checkbox"/> BVM	<input type="checkbox"/> VACUUM SPLINT
<input type="checkbox"/> SIMPLE FACEMASK	<input type="checkbox"/> TRACTION SPLINT
<input type="checkbox"/> VENTURI MASK	<input type="checkbox"/> VACUUM MATTRESS
<input type="checkbox"/> NON-REBREATHER MASK	<input type="checkbox"/> BOX SPLINT
<input type="checkbox"/> NASAL CANNULA	<input type="checkbox"/> FRAC STRAPS
<input type="checkbox"/> SAGE MONITOR	<input type="checkbox"/> SAM SPLINTS
<input type="checkbox"/> ETCO ₂ MONITOR	<input type="checkbox"/> EXTRICATION DEVICE
<input type="checkbox"/> INTUBATION	MISCELLANEOUS
<input type="checkbox"/> INTUBATION ATTEMPTED	<input type="checkbox"/> MINOR INJURY TREATMENT
<input type="checkbox"/> NEEDLE THORACOCENTESIS	<input type="checkbox"/> POSITIONING
CARDIAC SUPPORT	<input type="checkbox"/> BURNS DRESSING
<input type="checkbox"/> ECG MONITORING	<input type="checkbox"/> OTHER DRESSING
<input type="checkbox"/> 12 LEAD ECG	<input type="checkbox"/> NASO-GASTRO TUBE
<input type="checkbox"/> DEFIBRILLATION	<input type="checkbox"/> URINARY CATHETERISATION
<input type="checkbox"/> CHEST COMPRESSIONS	

CONTINUITY OF CARE			
PRACTITIONER	PIN	TIME	<input type="checkbox"/> HANDOVER <input type="checkbox"/> INTERVENTION
PRACTITIONER	PIN	TIME	<input type="checkbox"/> HANDOVER <input type="checkbox"/> INTERVENTION

ADDITIONAL INFORMATION	
CS LIFE THREATENING SERIOUS NOT LIFE THREAT.	<input type="checkbox"/> NON SERIOUS OR LIFE THREAT. <input type="checkbox"/>
CA	<input type="checkbox"/>

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CESSATION OF RESUSCITATION	
DEATH CONFIRMED BY DOCTOR:	
NAME <input type="text"/>	
CONTACT NUMBER	TIME
NUMBER <input type="text"/>	HH <input type="text"/> MM <input type="text"/>
OR	
PATIENT IS NOT:	
1	<ul style="list-style-type: none"> • Hypothermic <input type="checkbox"/> • Cold water drowning <input type="checkbox"/> • Poisoning <input type="checkbox"/> • Time to ACLS intervention < 15mins. <input type="checkbox"/> • Overdose <input type="checkbox"/> • Pregnant <input type="checkbox"/> • < 18 years <input type="checkbox"/>
OR	
CONFIRM ASYSTOLIC CARDIAC ARREST:	
2	<ul style="list-style-type: none"> Unresponsive <input type="checkbox"/> No signs of life, absence of central pulse and respiration. <input type="checkbox"/> Asystole on ECG monitor <input type="checkbox"/>
OR	
CONFIRM CPR:	
3	Confirm that two minute of CPR and "No Shock Advised" x 3 are completed <input type="checkbox"/>
OR	
NO SIGNS OF CIRCULATION:	
4	If still no signs of circulation: no pulse and no respiratory effort & Asystole <input type="checkbox"/>
OR	
CEASE RESUSCITATION	
REFERENCE CPG	

RECOGNITION OF DEATH	
DEATH CONFIRMED BY DOCTOR:	
NAME <input type="text"/>	
CONTACT NUMBER	TIME
NUMBER <input type="text"/>	HH <input type="text"/> MM <input type="text"/>
OR	
IT IS INAPPROPRIATE TO COMMENCE RESUSCITATION WHEN THE FOLLOWING INDICATORS OF DEATH ARE PRESENT:	
1	DECOMPOSITION <input type="checkbox"/>
2	RIGOR MORTIS <input type="checkbox"/>
3	INCINERATION <input type="checkbox"/>
4	DECAPITATION <input type="checkbox"/>
5	POOLING <input type="checkbox"/>
6	OTHER INJURIES TOTALLY INCOMPATIBLE WITH LIFE <input type="checkbox"/>
DOCUMENT WITH TWO 10 SECONDS RHYTHM STRIPS	
PLEASE SPECIFY NATURE OF INJURIES:	
<input type="text"/>	
REFERENCE CPG	

* OUT OF HOSPITAL CARDIAC ARREST	
HISTORY OF CORONARY DISEASE	
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDETERMINED	
1	COLLAPSE WITNESSED: <input type="checkbox"/> YES <input type="checkbox"/> NO BY BYSTANDER <input type="checkbox"/> BY CARDIAC FIRST RESPONDER <input type="checkbox"/> ASPIRIN GIVEN <input type="checkbox"/> YES <input type="checkbox"/> NO
2	TIME OF COLLAPSE <input type="text"/> HH <input type="text"/> MM <input type="text"/> <input type="checkbox"/> ESTIMATED TIME OF CHEST PAIN <input type="text"/> HH <input type="text"/> MM <input type="text"/> <input type="checkbox"/> ESTIMATED TIME CPR FIRST COMMENCED <input type="text"/> HH <input type="text"/> MM <input type="text"/> <input type="checkbox"/> ESTIMATED DURATION OF CPR <input type="text"/> HH <input type="text"/> MM <input type="text"/> <input type="checkbox"/> ESTIMATED
3	DEFIBRILLATION <input type="checkbox"/> YES <input type="checkbox"/> NO TIME FIRST RHYTHM ANALYSIS <input type="text"/> HH <input type="text"/> MM <input type="text"/> <input type="checkbox"/> ESTIMATED SPONTANEOUS PULSE RETURNED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ESTIMATED
4	TRANSFERRED TO HOSPITAL CPR IN PROGRESS <input type="checkbox"/> YES <input type="checkbox"/> NO SPONTANEOUS CIRCULATION ON ARRIVAL IN EMERGENCY DEPARTMENT <input type="checkbox"/> YES <input type="checkbox"/> NO
REFERENCE UTSTEIN STYLE 2004	

Module 4 Transfer patient to the proper health center

THROMBOLYSIS

INDICATION FOR THROMBOLYSIS EACH INDICATION MUST BE VERIFIED

Patient conscious, coherent and understands therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Patient consent obtained	<input type="checkbox"/> YES <input type="checkbox"/> NO
<75 Years	<input type="checkbox"/> YES <input type="checkbox"/> NO
MI Symptoms 20 minutes to 6 hours	<input type="checkbox"/> YES <input type="checkbox"/> NO
ST Elevation >1mm in two or more contiguous leads	<input type="checkbox"/> YES <input type="checkbox"/> NO

CONTRAINDICATIONS EACH CONTRAINDICATION MUST BE RULED OUT

Haemorrhagic stroke or stroke of unknown origin at any time	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ischaemic stroke in preceding 6 months	<input type="checkbox"/> YES <input type="checkbox"/> NO
Central nervous system damage or neoplasms	<input type="checkbox"/> YES <input type="checkbox"/> NO
Recent major trauma/surgery/head injury (within 3 weeks)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Gastro-intestinal bleeding within the last month	<input type="checkbox"/> YES <input type="checkbox"/> NO
Known bleeding disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO
Aortic dissection	<input type="checkbox"/> YES <input type="checkbox"/> NO
Transient ischaemic attack in preceding 6 months	<input type="checkbox"/> YES <input type="checkbox"/> NO
Oral anticoagulant therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pregnancy within 1 week post partum	<input type="checkbox"/> YES <input type="checkbox"/> NO
Non-compressible punctures	<input type="checkbox"/> YES <input type="checkbox"/> NO
Traumatic resuscitation	<input type="checkbox"/> YES <input type="checkbox"/> NO
Refractory hypertension (sys BP > 180mmHg)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Advanced liver disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Infective endocarditis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Active peptic ulcer	<input type="checkbox"/> YES <input type="checkbox"/> NO

CONSENT FOR THROMBOLYSIS

1 In order to avoid any ambiguity the consent information must be read to the patient.

1.1 "It is likely that you have had a heart attack. This means that one or more of your heart arteries has developed a blood clot. The best treatment to save heart muscle is a clot dissolving medication. The sooner you receive this medication the better. Like any medication there is a risk of serious side effects. The risks attached to this treatment are much less than the likely benefit.

The biggest risk is stroke which affects about one patient in every 200. It can also cause bleeding and allergic effects that do not usually cause any major problem."

If the patient enquires why he/she cannot wait to have the medication in hospital the following should be read to him/her:

1.2 "The recommended time frame for having the medication is within one hour of you calling for help. It is not possible to be in hospital within that time frame. A clinical practice guideline was developed for this very situation."

2 Do you consent to this medication being given?

3 Two practitioners must verify, by entering their PIN, that the indications are present, the contraindications have been ruled out and that consent was obtained from the patient prior to administering a thrombolytic agent.

PIN (1) _____

PIN (2) _____

REFUSAL OF TREATMENT AND OR TRANSPORT

"I/We witness that the patient has refused treatment/transport to the ED. I/We have advised the patient to consult with his/her own doctor as soon as possible or should his/her condition deteriorate to call for the assistance of an emergency ambulance"

Signed : _____

PIN (1) _____

PIN (2) _____

or report back to Control.

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5. Coding by symptoms and signs. The international classification of diseases

To unify databases interventions with patients and facilitate treatment for research work, the classification of disease and symptoms is used according to the CIE international system.

Each disease is assigned a category and receives a code of up to six characters (X00.00 format). ICD is the acronym for International Classification of Diseases published by the World Health Organization (WHO).

6. Hospital triage

The hospital triage is:

- A method of classification and selection.
- Used by professional intended for that purpose in the emergency room, doctor or nurse practitioner, according to what the patient has and clinical findings.
- A method that sets the priority for the care of a patient in the emergency department depending on the severity of your condition.

Directed not to diagnose, but to set the priority of care.

Used for:

- Identify the severity of the urgency of users (life-threatening).
- Determine the maximum waiting time for treatment at the institution (classification level: red-yellow-green-white).
- Inform patients and their families.
- Reduce congestion of service.

7. Functions of the technician related to transfer

7.1. Limits, rights and obligations of the Emergency Medical Technician

Our laws provide a rights connected with the user of the system of health care. The Technician is another member of this system, and as such must fulfill its assigned mission. Therefore, the first thing to do is to define briefly the duties and obligations of the Technician.

- The Technician is required to assist the victims of an accident on a public road, public place or domicile, and then transferred to a hospital. This assistance shall be within the limits of their professional training and education.
- Technician is subject to the same rules regarding booking information and professional secrecy, to any other health professional.
- Dealing with the patient must be correct at all times, not allowing any contempt or discrimination.

In Ireland, all practitioners must be Pre Hospital Emergency Care Council (PHECC) registered with a unique pin number and ID.

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7.2. Patients' rights

- The patient has the right to a correct and current assistance. The technician must be trained to the extent that their work requires.
- The patient has the right to reject any or all proposals or therapeutic refuse to be moved or care. Given this attitude, the Technician must accept the will of the patient and facilitate as far as possible the process. Never coerce the patient to accept the transfer, which does not conflict with making recommendations technically appropriate.
- The patient has the right to know the identity of the person treating him. The technician can not hide his identity acting anonymously.
- The patient has the right to be provided with written and understandable information about the procedure that has been done. Technician report shall provide assistance in all the information contained in the work.
- The Technician, in his work, has an important relationship with other health and non-health professionals (police, firefighters, civil protection...). This relationship should be full cooperation, with the sole purpose of providing the best patient care possible.

The relationship with other health professionals should be cordial, considering the unique premise that health decisions are made and coordinates by the senior healthcare professional of all involved, avoiding contravening decision of a doctor or a graduate in nursing.

- The technician should facilitate maximum possibility that the patient may have medical staff care in the accident, avoiding the transfer of the patient to the imminent arrival of this staff.
- Once at the hospital which has been transferred to the patient, the technician must transmit all the information available to it regarding the patient and the accident. The information transmitted must be objective and based on observed evidence, not on subjective and unclear issues.

8. Legal responsibility

To their understanding within a legal context, we define:

Responsibility: title or moral obligation for someone result error in a particular case. In Legal: capacity in all active subject of right to recognize and accept the consequences of an act done freely.

Neglect: neglect, lack of care, application.

Infringement: trespass, breach of a law, agreement or treaty, or a moral, logical or doctrinal standard.

Sanction: a penalty statute or regulation provides for their offenders.

Offense: voluntary or negligent act or omission punishable by law.

Dolo: deliberate intention of committing a crime to knowingly unlawful.

Foul: voluntary or negligent violation of a standard, which can be punished either criminally or administratively or by the employer in labor relations.

Reckless endangerment: serious and inexcusable negligence.

Foolhardy: too reckless, it faces, no sign of cowardice to hazards.

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In the current model of values, the process of care and health care evolves toward the practice of “defensive” way, since the changes, particularly economic, condition the medical-patient relationship, and between the components themselves of the health team-system. This situation tends to generate anxiety among health workers for fear of being accused in a liability claim.

The law only punishes the careless behavior, lack of due care and reckless oblivion. The Act should not worry who runs their profession responsibly and with integrity.

The fundamentals for proper health care in emergencies are:

- The updating of knowledge as unavoidable necessity.
- The special circumstances of time and place in which care is delivered.
- The importance of media available.
- The duty to inform and obtain consent.
- The risk that we may consider as permitted.

8.1. Types of responsibility

1. **Liability:** be responsible is to assume the consequences of damage by act or omission that causes harm to another, being obliged to repair (Article 1902 of the Civil Code).
2. **Criminal Responsibility:** either by fraud when there is intent on the action of the subject, ie, desire to cause and / or knowledge to act against the dictates of the rule and by fault or negligence, if there is no intent to cause damage, provoking this however; will result from careless behavior, omitting due diligence.

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For there to be reckless in our field is required:

- Action or willful default.
- The conduct involving breach of duty of care required.
- An effective and concrete harm to the health of people.
- A causal relationship between the conduct performed and damage.

