



Standard Operating Procedure Hospital Pre-alert & Patient Handover

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To be read in association with the following Trust documents;	
Target audience: All Trust EMS/HDS staff conveying patients to Accident and Emergency Hospital Departments	

Version History

Version	Date	Directorate	Status	Comment
0.1	04/12/ 08	Clinical Directorate	Draft	Consultation process prior to Approval
1.1	11/12/08	Clinical Directorate	Draft	Equality Impact Assessment
1.1	01/02/09	Clinical Directorate	Draft	Consultation process. Control/LAO/A/E/CTL/Staff Side
1.2	19/03/09	Clinical Directorate	Draft	Changes after consultation with stakeholders
1.3	10/07/09	Clinical Directorate	Final Draft	Final draft for submission to Workforce Policies and Procedures Working Group (24/09/09).
1.4	9/12/09	Clinical Directorate	Final Draft	Clarity on use of ASHICE section 3.0. Reference to SBAR section 4, following feedback from WPPWG
2.0	17/02/10	Clinical Directorate	Approved	Executive Management Committee

Please Note:

This document is available in other languages, large print and audio format on request

1.0 Purpose

The aim of this Standard Operating Procedure is to ensure that the Welsh Ambulance Services NHS Trust (WAST) has a consistent approach to pre-alerting receiving hospitals. Providing an appropriate level of information about a patient's condition allows receiving hospitals to determine the level of preparation and staff required to receive a critically ill or injured patient. Concise and accurate information transfer between the crew, control and the receiving hospital also reduces the need for unnecessary communications, thereby reducing the burden on busy ambulance control centres.

2.0 Scope

This Standard Operating Procedure provides guidance to operational ambulance crews, ambulance control staff and hospital staff working in receiving units. This SOP is applicable to all types of critically ill or injured patients, e.g. trauma, medical, obstetric, and supersedes any other Regional or National WAST policy relating to hospital pre-alerts.

It is also commensurate with the recommendations of;

- “*Better Care for the Severely Injured*” a joint report published by the Royal College of Surgeons and the British Orthopaedic Association, July 2000
- The Joint Royal Colleges Ambulance Liaison Committee UK Clinical Practice Guidelines 2006.
- National Institute of Health & Clinical Excellence (NICE) Head injury: Triage, assessment, investigation and early management of head injury in infants, children and adults
- National Confidential Enquiry into Patient Outcome and Death, Major Trauma Report 2008

3.0 Criteria for Initiating a Hospital Pre-alert (ASHICE)

An ASHICE message should be considered for any patient whose clinical condition suggests **that special arrangements have to be made** by the receiving hospital, to prepare for the patients arrival. e.g. trauma, medical, or paediatric teams; urgent cardiac assessment (early thrombolysis), or obstetric emergencies.

ASHICE messages should **not** be used for routinely informing DGH's of all non-critical imminent patient arrivals. The following criteria are not exhaustive and provide guidance only.

3.1 Trauma

- Severe airway compromise or intubated patient
- Severe respiratory distress
- Haemodynamically unstable patients (signs and symptoms of shock).
- GCS < 9 or fall in GCS of more than 2 points since patient contact
- Casualty ejected from vehicle
- Penetrating injury to the trunk
- Any gunshot wound
- Significant mechanism of injury (the common sense approach)
- Inhalation burns
- Child burns > 10%
- Adult burns > 15%
- Any other condition giving the attending staff cause for concern

3.2 Medical

- Airway compromise
- Severe breathlessness/distress
- Failing ventilation
- Severe haemorrhage
- Circulatory collapse and shock due to infection
- Cardiac chest pain.
- Cardiac patient with any ST elevation indicative of an acute myocardial infarction
- Cardiogenic shock
- Severe Hypotension due to bradycardia or extreme tachycardia
- Anaphylaxis
- Unconsciousness
- Status epilepticus
- Any other condition giving the attending staff cause for concern

3.3 **Obstetric and Gynaecology**

- Haemorrhage where systolic BP is <100mmhg or pulse rate >90bpm
- Tender uterus (with or without haemorrhage)
- Systolic blood pressure >160mmhg or diastolic blood pressure >95mmhg
- Convulsion either active or any history during pregnancy
- GCS <15
- Obstructed labour
- Vulval presentations (Feet, Head, Breech presentations, or Membranes)
- Pre-term labour (before 37 weeks or 3 weeks of estimated date of delivery EDD)
- Birth imminent or baby born during transport
- Signs of foetal distress (meconium)
- Any other condition giving the attending staff cause for concern

3.4 Having confirmed a patient meets the criteria for an ASHICE, concise and appropriate information should be passed to ambulance control using the A.S.H.I.C.E format as detailed below. *(An aide memoir can be found in appendix 1 of this document and may be printed off and used by hospital receiving units).*

A Age
S Sex (Gender)
H History
I Injury/Illness
C Condition
E Estimated time of arrival (ETA)

Laminated copies of the aide memoir (appendix 1) will also be available for reference on all front line vehicles and in ambulance controls.

- 3.5 On receipt of an ASHICE from the crew, EMS Control will record the information on the MIS system and repeat the ASHICE back to the crew to ensure accuracy. The crew will then confirm its accuracy.
- 3.6 EMS control will contact the appropriate receiving hospital department and relay the crews ASHICE message. On completion, EMS Control will ask the member of hospital staff receiving the ASHICE message to repeat the information, to ensure its accuracy and correct or confirm as required.

- 3.7 There should be no further need for additional communication between EMS Control or the hospital department unless there is a significant change in the patient's condition. Based on the information received, the receiving hospital can determine the level of response required.

NB. *It should be noted that the ASHICE aide memoir (appendix 1) is a generic format to ensure a consistent level of information is passed. Whilst it is recognised there may be some merit in developing specific formats for certain categories of patients, the most important point is that the information passed is relevant to the individual patient and their condition.*

4.0 Patient Handover

- 4.1 On arrival at the receiving unit the ambulance clinician will provide an initial concise verbal handover to the receiving team, to ensure the patient is directed quickly to the most appropriate acute treatment area.
- 4.2 On arrival at the treatment area, the receiving team should be provided with a more detailed and holistic handover, which can be supported by use of the SBAR (Situation, Background, Assessment & Recommendation) tool.
- 4.3 To ensure continuity of care, one ambulance clinician may wish to complete their Patient Clinical Record (PCR) in the resuscitation room, whilst the other makes the vehicle ready.
- 4.4 On completion of the PCR the yellow copy together with any ECG strips or patient notes/doctors letter, should be handed over. The crew will then inform control of their availability for further duties.

Hospital Pre-Alert Form

A.S.H.I.C.E.

AGE	<i>SURNAME</i> _____ <i>AGE</i> _____ <i>D.O.B.</i> ____ / ____ / ____		
SEX (Gender)	Male Female		
HISTORY	<i>Type of pain?</i> <i>Onset of pain?</i>		
INJURY/ ILLNESS			
CONDITION	Respiratory Rate	Heart Rate	Blood Pressure
	AVPU or GCS	Trauma Score	Intubated? Y N
	Cannulated? Y N	Drugs Given?	Defibrillated?
	STEMI / NSTEMI?	FAST TEST Normal / Abnormal	Needle Crichothyrotomy []
			Needle Thoracocentesis []
			Intraosseous []
	ETA (minutes)		
RECEIVING UNIT			