Patient Assessment and Transport

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MINIMUM EQUIPMENT TO BE CARRIED UPON APPROACH TO THE PATIENT
The minimum equipment to be carried upon initial approach to a patient will often depend on a variety of factors, including the location of the patient (on the street, in a home, at a construction site), the number of EMS personnel arriving (single Supervisor vs. two person BLS or ALS crew), level of certification of the EMS personnel involved (e.g.: Basic Life Support vs. Advanced Life Support), the number of patients (single patient vs. multiple casualty incident), the age of the patient, and the reported nature of the emergency (medical call vs. trauma).

In general, the minimum equipment to be carried by BLS personnel upon the initial approach to a patient will be a jump kit/first aid kit, “green bag” (with oxygen and BVM), and semi-automatic defibrillator. A stair-chair, wheel-cot, or other appropriate means of transporting the patient to the ambulance shall also be brought to the patient’s side upon initial approach. Minimum equipment to be carried by ALS personnel upon the initial approach to a patient will be a jump kit, “green bag” (with oxygen and BVM), monitor / defibrillator, and medication box. When the ALS crew is sent “solo” or there will be a significant delay until the arrival of the BLS crew, the ALS crew should also bring a transport device upon initial patient approach.

SHARED RESPONSIBILITY FOR PATIENT CARE
When EMS was in its infancy, the “ambulance driver” and “attendant” had very defined roles. Because the “ambulance driver” had no medical training, all patient care activities were the responsibility of the “attendant”. Nowadays, both crewmembers are highly trained medical professionals and essentially act as team at the scene of an emergency. As such, all members on scene have a duty to ensure that the patient is receiving adequate and appropriate treatment. Disagreement over the scope of patient care shall be settled with a conservative approach. For example, if there is a question as to whether a splint should be applied or not, the splint shall be applied; if there is any question as to whether oxygen should be administered, or a long backboard should be applied, the more aggressive course of treatment shall be pursued.

Patients to be Carried to THE Ambulance

Personnel are reminded not to allow patients with certain medical or trauma conditions to walk, or otherwise exert themselves. A patient with any of the following conditions should be carried by the appropriate means (stair chair, wheeled-cot, orthopedic stretcher, etc.) to the ambulance:

- Abdominal Pain

- Altered Mental Status / Unconscious
- Cardiac Related Chest Pain
- CVA (Stroke)
- Pregnancy: Active Labor
- Pregnancy: Vaginal Bleeding
- Respiratory Distress
- Seizure Disorder
- Significant Head Injury or other trauma
- Syncope; Orthostatic or Hypotensive Patient
- Suspected Lower Extremity Fracture or Sprain
- Suspected Pelvic Fracture
- Restrained patients
- Any elderly, physically challenged, intoxicated, or other patient with difficulty ambulating
- Patients who specifically ask to be carried, or otherwise demonstrate their expectation to be carried (e.g.: "It hurts too much to walk" or "I would have driven myself but I couldn't get down the stairs", etc.)

Patients shall be appropriately covered to keep them warm and dry, and to maintain their privacy to the extent possible. Whenever a patient refuses to be carried and instead insists on ambulating against medical advice, the patient shall be assisted to the extent possible and closely monitored to prevent further injury. This refusal to be carried shall be documented on the patient care report.

SAFETY TIPS

- Prior to moving a patient, personnel should assess the scene for hazards that may inhibit moving the patient safely (plush carpet; soft ground; inclined surfaces; narrow hallways etc.)
- Select and utilize the proper lifting device
- Know your physical abilities and limitations and also those of your partner
- Use proper lifting techniques and keep the weight you're lifting close to your body
- Communicate clearly and frequently with your partner(s). Verbalize all commands
- Don't hesitate to request assistance with the lift or movement of the patient
- Once on a wheeled-cot, a patient should <u>never</u> be left unattended. Whenever moving a raised stretcher, especially on an incline or uneven surface, use a minimum of two operators to manipulate the cot. When the stretcher is stationary on a flat surface, such as at a hospital triage area, at least one member shall remain with the patient to control the stretcher and prevent it from moving or tipping over. In such cases, whenever possible, the stretcher should be buttressed against a wall for additional support.

PATIENTS TO BE TRANSPORTED ON WHEELCOT

<u>Securing Patient</u>: Prior to beginning transport, the patient shall be properly secured to the ambulance cot, using all of the required straps. Buckle the 5-point restraint straps across the patient's chest/shoulders, waist, and legs to minimize horizontal, latitudinal

and rotational movement. If patient care requires that a strap be removed, the strap must be re-secured as soon as practical". Patients who are ambulatory may be assisted to a wheelchair upon arrival at the hospital for transport into the emergency room.

In the event a patient adamantly refuses to be transported by stretcher, a field supervisor may be requested to respond to witness the refusal. However, transportation should not be unduly delayed, especially if it may adversely affect the patient's condition. In any case, the patient's refusal to be transported on the stretcher must be fully documented on the patient care report. All PCRs in which a patient was noted to be transported on bench seat will be reviewed by the appropriate Shift Commander.

Patients that are a potential management issue and/or flight risk for whatever reason, but do not require restraint may be secured using a "BuckleGarde" or similar type device. BuckleGarde is a security cover that surrounds the release mechanism of the seatbelt, deterring the patient from actuating the push button and releasing the buckle. If the patient attempts to release the safety buckle, the device is intended to introduce enough of a delay for other interventions to be taken. Personnel must have immediate access to a pair of scissors, key, or other device to remove the BuckleGarde should the patient seize or need to be repositioned.

Multiple Patients: In cases where more than one patient is being transported simultaneously in the same ambulance, additional patients must be transported in a position appropriate to the chief complaint and/or nature of the illness or injury and properly secured to the squad bench.

Children: Children should ideally be transported in a size-appropriate car seat that is properly secured to the ambulance cot. If this is not practical or achievable, a child whose condition does not require continuous and/or intensive medical monitoring may be transported in the integrated Guardian Safety seat. If this is not available, or the child requires continuous and/or intensive medical monitoring or interventions, the child should be secured to the cot head first with horizontal and vertical (shoulder) restraints. A child whose condition requires spinal immobilization and/or lying flat should be secured to a size-appropriate spine board and secure the spineboard to the cot, head first, with a tether at the foot (if possible) to prevent forward movement. A child should never be transported while unrestrained or held in an adult's lap or arms.

RELATIVE OR FRIEND ACCOMPANYING PATIENT

At the discretion of the crew, a reasonable effort shall be made to accommodate transport of an accompanying family member or friend of the patient. All passengers shall have a seat belt engaged. A minor child should not accompany a patient to the hospital unless there is no appropriate adult supervision on scene.

An injured or sick child who is to be transported to a hospital or other medical facility by an ambulance or other emergency vehicle shall be accompanied by a parent upon such parent's request, unless the emergency medical technician or other person in charge determines that the medical situation is life threatening or that the presence of a parent

would create a potential risk to such child. Such determination shall be noted in the written report of said emergency medical technician and a copy of such report shall be sent to such parent within thirty days of such determination. (MGL Chapter 111C, section 17);

At the discretion of the crew, the parent or guardian of a pediatric patient may accompany the patient in the rear compartment of the ambulance.

NHTSA Working Group Best-Practice Recommendations for the Safe Transportation of Children in Emergency Ground Ambulances, September 2012. http://www.ems.gov/BestPracticeRecomendations.htm