CGP110

National Ambulance
CLINICAL POLICY AND PROCEDURE
PATIENT ASSESSMENT/REASSESSMENT & TRIAGE

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1. POLICY INTRODUCTION

National Ambulance (NA) strives through development of Policies, Procedures and Guidelines to deliver clinical services in accordance with international evidence based best practices through protocols and other clinical policies, procedures and guidelines approved and/or published by National Ambulance.
Patient assessment is the very first part of the emergency care process. It is the process involving the identification of a condition and thus forms the basis of your treatment plan. Every decision made regarding patient treatment is based on the findings during the patient assessment/reassessment.
This policy applies to all staff involved in patient care and ensures compliance with regulatory requirements and is related to the following Management component, 'Continuous Improvement'. Therefore, through processes of clinical quality reviews, complaints & investigations, audits and other opportunities patient assessment and care will be reviewed.

2. SCOPE

Assessment, care and management of a patient is only to be performed by National Ambulance Clinical personnel as within their scope of practice, approved competencies and in accordance with their qualifications, skills, experience and training in compliance with CGP134 - National Ambulance Patient Care Protocols.
This policy and procedure includes all elements of patient assessment/reassessment and triage in the Emergency medical services environment to ensure best possible outcomes; it also includes requirements for documentation to ensure comprehensive and accurate recording of all patient assessment activity takes place.

3. ROLES AND RESPONSIBILITIES

3.1. **THE CHIEF OPERATIONS OFFICER** is responsible for the implementation and monitoring of this Policy and Procedure.

3.2. **MEDICAL DIRECTOR/MEDICAL DELEGATE** is responsible for development of this Policy and Procedure, review and revision and any Performance Indicators and should be available for advice and support The MD is also responsible for developing training to support this Policy and Procedure

3.3. **ALL OPERATION MANAGERS** are responsible for ensuring that staff have induction in alignment with this Policy and Procedure, for monitoring the applicability and ongoing implementation as well as raising any issues with the MD and reporting any incidents or near misses through the QHSE system. Reporting of the suspected or confirmed communicable disease must be completed in accordance with the DOH/MOH regulations found in CGP124 - Care of Patients with Suspected Confirmed Communicable Diseases or Immune Compromised.

3.4. **CLINICAL GOVERNANCE AND AUDIT OFFICER** works under the direction of the MD in enabling the implementation of this policy and the monitoring of PCRs is undertaken to ensure quality and accurate completion.

3.5. **ALL CLINICAL STAFF** are responsible for acting according to this policy and procedure in accordance with their scope of practice. They are also responsible for ensuring that they attend or pursue any relevant training recommended by their supervisors. (i.e. eLearning and face to face training).

4. POLICY STATEMENT

National Ambulance clinical staff must act in the best interests of the patient, any relatives or guardians accompanying the patients and within their specified scope of practice and must use relevant qualifications, training, skills and experience to provide optimal clinical care.
All relevant information should be recorded using the NA approved Patient Care Records (PCR).
National Ambulance clinical staff must have knowledge and understanding of National Ambulance approved and published documents including but not limited to:

- CGP 105 Patient Consent Policy and Procedure
- CGP 113 Patient Rights and Responsibilities Policy and Charter.
- CGP 115 Patient Transportation Policy & Procedure and
- CGP 119 Patient Care Documentation and Patient Care Record Policy and Procedure
- CGP 134 Patient Care Protocols

National Ambulance will ensure that:

- All clinical staff have adequate resources to enable them to provide optimum assessment and care such as equipment and vehicles, medical gases and drugs.
- All clinical staff will have access to ways to record and report all elements of patient assessment
- All clinical staff have access to suitable ongoing training to ensure they have the most relevant and up to date information and that they have access to ongoing support in the workplace.
- Other relevant policies, procedures and guidelines are in place and available to support this policy and procedure.
- All clinical staff adhere to and are compliant with the relevant policies, procedures and guidelines.

4.1. WHY THIS IS IMPORTANT FOR YOU?

As an a licensed clinician you have a responsibility:

4.1.1. To ensure that you have the knowledge, training and skills to give the best quality and safest patient care.
4.1.2. To protect yourself by reading and understand all documents related to your work as well as completing ongoing learning and development.
4.1.3. To be fully prepared to assess and manage patients with a variety of conditions including circulatory disorders especially Ischemic Heart Disease, Diabetes and trauma events.

4.2. WHAT YOU NEED TO KNOW?

- Reading this document and following the stepwise approach to acquire knowledge you need to assess and re-assess all patients. Information you will need is mainly contained in this Clinical Policy and Procedure.
- However, it is also up to you to use your professional judgement and your knowledge of the relevant documents that are mentioned in the Policy.
- These Policy and Procedures are designed for best practice; it is not possible to write a Policy and Procedures on patient assessment/re-assessment for every condition that a patient may have
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- You need to complete the LMS course for CGP134

- You should follow the Clinical Policy and Procedure details as shown below, in addition you must communicate your findings, the care you are giving and the outcomes to your colleagues, any other health professionals involved in the patient treatment and any other involved party where appropriate such as patient, relative or consent giver.
- You must act in the best interests of the patient and perform within your scope of practice.
- It's imperative that you work as a team and provide a consistent standard of care to the patients in the pre-hospital field.
- The most senior qualified licensed clinician is to assume the leadership role.
- When you have carried out the assessment you must document comprehensively and accurately all your findings and all relevant information required for the NA Patient Care Record (PCR).

4.3. The Initial Approach

Follow general guideline from CGP 134 – Patient Care Protocol
For every patient, whether it is a medical or trauma case,

- Always assure scene safety for yourself, your fellow rescuers, and your patient.
- Consent should be obtained for all patient when it is applicable.
- In trauma patients, it's important to try and determine the mechanism of injury
- in medical patients; the survey may give you an idea on the medical circumstances.

4.4. The Primary Assessment (Initial Assessment)

This is the initial assessment done on the patient and where time critical problems are identified and corrected. On arrival to a scene, ideally assessment must commence as soon as possible (within 1-2 min) with due consideration for consent and accessibility.
Begin by speaking to the patient. Clinicians should state their names, tell the patient that they are emergency medical team, and explain that they are here to help

4.4.1. Assess the patient ABCDE:

A – Airway. Ensure the airway is secure before moving on. Consider C-Spine immobilization.

B – Breathing. Correct any breathing problems before moving onto the next step.

C – Circulation. Correct circulation issues. Check for major bleeding and control. Be aware that the patient may have internal bleeding. Check the skin color and temperature. If necessary, insert an IV and run the appropriate fluid.

D – Disability. Perform a focused neurological examination. Screen the patient for pain, if the patient has pain determine its level using the pain scale. Serial pain assessments are recommended with a minimum of two scores being recorded (before and after) Check pupils. In medical patients, if a stroke or TIA is suspected, use the BE FAST Test.

E- Exposure.

4.4.2. Assess Level of patient's neurological / Mental status (AVPU):

1. Alert
2. Responds to Verbal stimuli
3. Responds to Painful stimuli
4. Unresponsive - no gag or cough

4.4.3. D E F G – "DON'T EVER FORGET GLUCOSE"!

Check blood glucose level (BGL) for all patient, if clinical indicated, (altered mental status including unconsciousness) and if necessary, administer treatment according to appropriate protocol. Reassess blood glucose level 5 minutes after each treatment and record on PCR.

4.5. REASSESSMENT (CONTINUOUS)

- Patients should be reassessed frequently according to clinical status, at regular intervals and after any intervention.
- Primary assessment within 1-2 minutes or as soon as consent obtained
- Reassessment every 5 minutes for severe and critical patients,
- Reassessment every 15 minutes for mild and moderate patients,
- At least two sets of observations must be completed and documented (mandatory).
- Patients can deteriorate quickly, and it is important that this is recognized and treated promptly.
- Continuous monitoring is required for all patients considered to be of high risk.
- Crews should obtain a set of baseline vital signs on arrival at the patient. This will give the crews an indication on whether the patient is deteriorating or improving.
- If for any reason you do not perform at least two sets of observations, you should write the reason for this in the free text box.
- Pain scales are to be reassessed to determine whether further pain relief is necessary or not in accordance with CGP113 - Pain Management Policy and Procedures.
- If further management of the patient is required beyond the scope of practice of the attending clinician, this must be noted on the PCR and the information provided to the clinician at the receiving facility or provide to the patient's physician for further follow (CAD reference number to be provide to the patient)
- **Falls Assessments** are required to be undertaken prior to patient movement. Follow OPF251 Fall Risk Assessment Tool.

4.5.1. ASSESS AND NOTE THE PATIENT BEHAVIOUR:

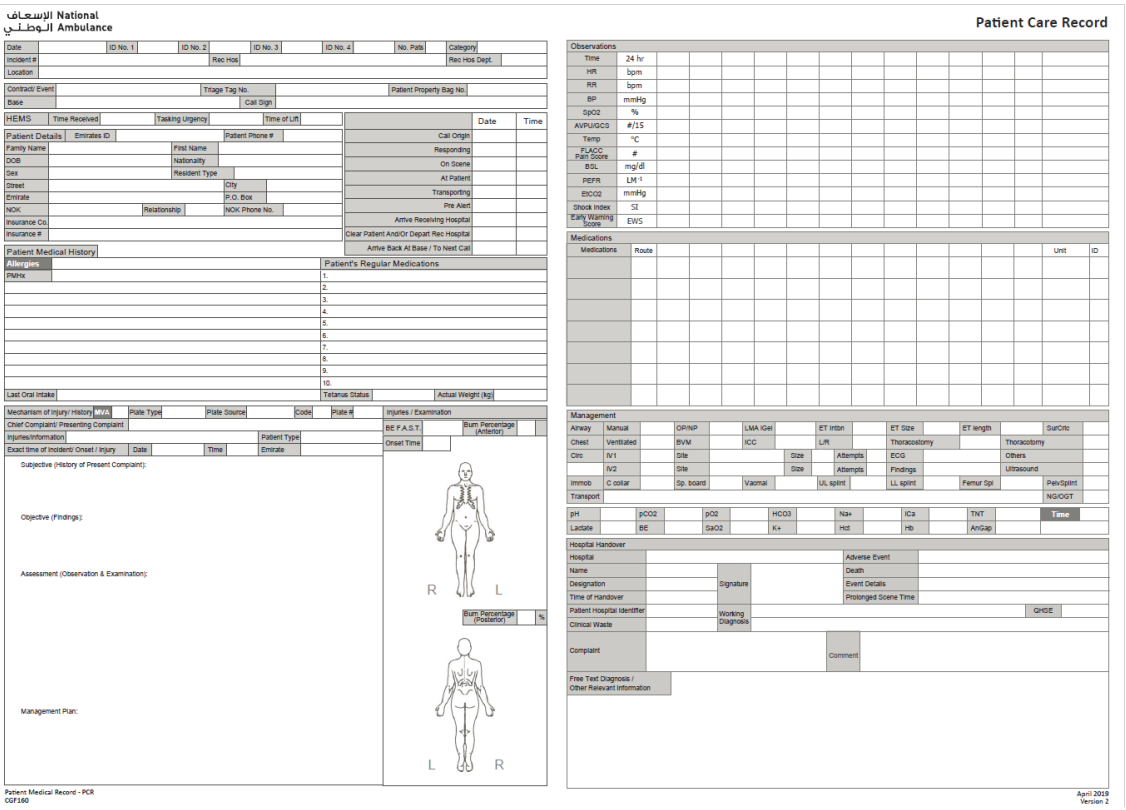
- Speak to relatives if the patient behaving abnormally and ask them about past abnormal behavioral history.
- Note all related information in the PCR
- Please ensure that the patient's response to interventions is monitored closely.

Following the primary assessment and urgent intervention is done, rapid transportation is required and the reassessment can be done en route

Please note:

- All persons that you are in contact with at any time are considered as patients that have been treated by you irrespective of how brief the interaction or how minor the intervention
- Guidance on completion of PCR can be found in CGP119 – Patient Care Documentation and Patient Care Record Policy
- All assessments such as taking a blood pressure or pain scores should be documented
- The advice given should be documented
- Do not document any patient assessment information that has not been carried out by you or your clinical colleagues.
- Record reasons why any element of assessment has not been carried out in the free text box of the PCR.
- Assessments of patients before, during and after any treatment or procedure being provided to any patient is essential with any changes being documented in the PCR. (This includes any clinical procedures, drug administration other intervention involving patient care)
- All pertinent information of assessment should be documented. An incomplete PCR is considered as non-compliant.
- Each patient shall have an initial physical, Emotional and neurological assessment completed.

The highlighted area below indicates where to document the reassessment of observations and vital signs on the National Ambulance PCR.



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Patient Care Record

Date | ID No. 1 | ID No. 2 | ID No. 3 | ID No. 4 | No. Pats | Category
Incident # | Rec Hos | Rec Hos Dept.
Location

Contract/ Event | Triage Tag No. | Patient Property Bag No.
Base | Call Sign

HEMS | Time Received | Tasking Urgency | Time of Lift

	Date	Time
Call Origin		
Responding		
On Scene		
At Patient		
Transporting		
Pre Alert		
Arrive Receiving Hospital		
Clear Patient And/Or Depart Rec Hospital		
Arrive Back At Base / To Next Call		

Patient Details | Emirates ID | Patient Phone #
Family Name | First Name
DOB | Nationality
Sex | Resident Type
Street | City
Emirate | P.O. Box
NOK | Relationship | NOK Phone No.
Insurance Co.
Insurance #

Patient Medical History
Allergies
PMHx

Patient's Regular Medications
1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Last Oral Intake | Tetanus Status | Actual Weight (kg)

Mechanism of Injury / History | MVA | Plate Type | Plate Source | Code | Plate #
Chief Complaint/ Presenting Complaint
Injuries/Information | Patient Type
Exact time of Incident/ Onset / Injury | Date | Time | Emirate

Subjective (History of Present Complaint):

Objective (Findings):

Assessment (Observation & Examination):

Management Plan:

Injuries / Examination
BE F.A.S.T. | Burn Percentage (Anterior)
Onset Time

R L

Burn Percentage (Posterior) %

L R

Observations

Time	24 hr												
HR	bpm												
RR	bpm												
BP	mmHg												
SpO2	%												
AVPU/GCS	#/15												
Temp	°C												
FLACC Pain Score	#												
BSL	mg/dl												
PEFR	LM^{-1}												
EtCO2	mmHg												
Shock Index	SI												
Early Warning Score	EWS												

Medications

Medications	Route											Unit	ID

Management

Airway	Manual		OP/NP		LMA /Gel		ET intbn		ET Size		ET length		SurCric		
Chest	Ventilated		BVM		ICC		LR		Thoracostomy			Thoracotomy			
Circ	IV/1		Site			Size	Attempts		ECG			Others			
	IV/2		Site			Size	Attempts		Findings			Ultrasound			
Immob	C collar		Sp. board		Vaomal		UL splint		LL splint		Femur Spl		PelvSplint		
Transport													NG/OGT		

pH		pCO2		pO2		HCO3		Na+		iCa		TNT	Time
Lactate		BE		SaO2		K+		Hct		Hb		AnGap	

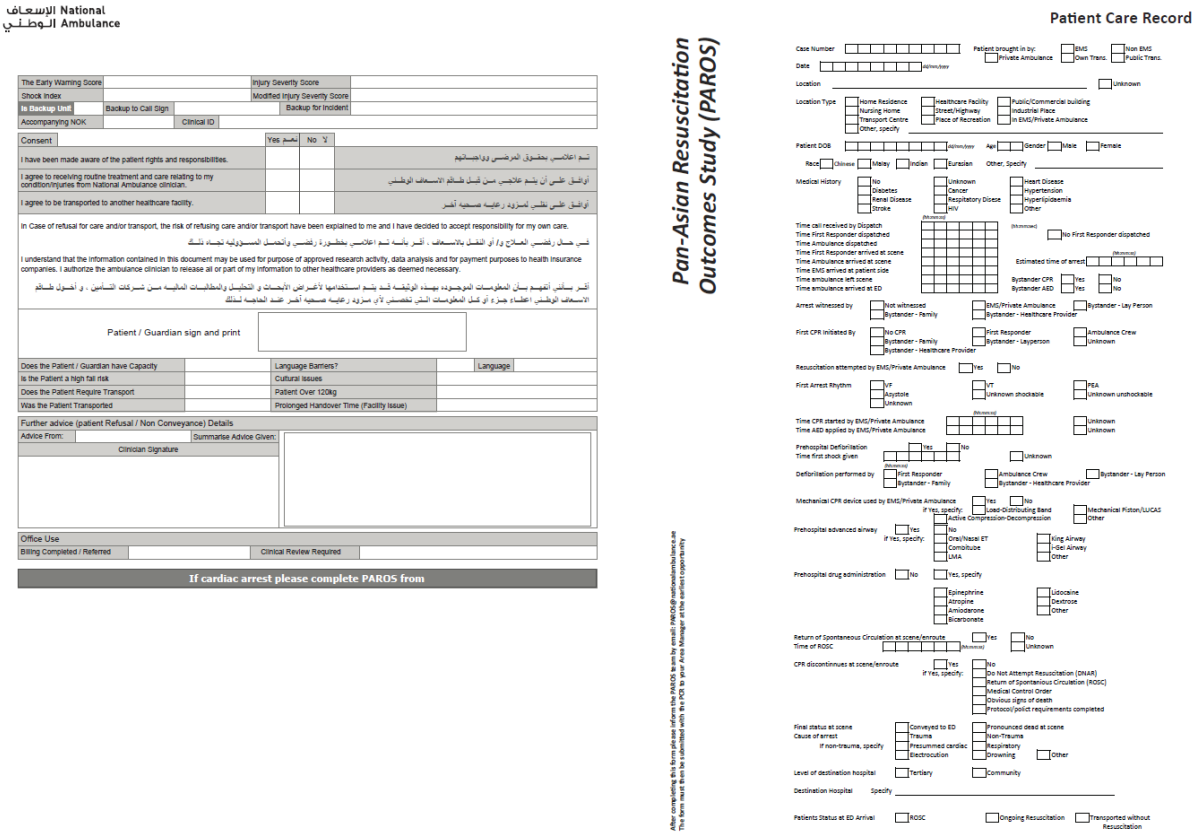
Hospital Handover

Hospital		Adverse Event	
Name		Death	
Designation	Signature	Event Details	
Time of Handover		Prolonged Scene Time	
Patient Hospital Identifier	Working Diagnosis	GHSE	
Clinical Waste			
Complaint	Comment		

Free Text Diagnosis / Other Relevant Information

Patient Medical Record - PCR
CGF160

April 2019
Version 2



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The Early Warning Score		Injury Severity Score	
Shock Index		Modified Injury Severity Score	
In Base/Log Unit	Backup to Call Sign	Backup for Incident	
Accompanying NOK	Clinical ID		

Consent	Yes نعم	No لا	
I have been made aware of the patient rights and responsibilities.			تم اعلامي بحقوق المرضى وواجباتهم
I agree to receiving routine treatment and care relating to my condition/injuries from National Ambulance clinician.			أوافق على أن يتم علاجي من قبل طاقم الاسعاف الوطني
I agree to be transported to another healthcare facility.			أوافق على نقلي لمنزوله رعايه صحيه أخر

In Case of refusal for care and/or transport, the risk of refusing care and/or transport have been explained to me and I have decided to accept responsibility for my own care.
تمى شرح رفضي العلاج و/ أو النقل بالاسعاف . أقر بأنه تم اعلامي بخطورة رفضي والتحمل المسؤولية نتيجة ذلك

I understand that the information contained in this document may be used for purpose of approved research activity, data analysis and for payment purposes to health insurance companies. I authorize the ambulance clinician to release all or part of my information to other healthcare providers as deemed necessary.
أقر بأنني أفهم بأن المعلومات الموجوده بهذه الوثيقه قد يتم استخدامها لأغراض الأبحاث و التحليل والمطالبات المالية من شركات التأمين . و أخول طاقم الاسعاف الوطني اعطاء جزء أو كامل المعلومات التي تخصني لأي مزوده رعايه صحيه أخر عند الطلبه لذلك

Patient / Guardian sign and print

Does the Patient / Guardian have Capacity		Language Barriers?	Language
Is the Patient a high fall risk		Cultural Issues	
Does the Patient Require Transport		Patient Over 120kg	
Was the Patient Transported		Prolonged Handover Time (Facility Issue)	

Further advice (patient Refusal / Non Conveyance) Details
Advice From: | Summarise Advice Given:
Clinician Signature

Office Use
Billing Completed / Referred | Clinical Review Required

If cardiac arrest please complete PAROS from

Pan-Asian Resuscitation Outcomes Study (PAROS)

Patient Care Record

Case Number | Patient brought in by: EMS | Non EMS | Private Ambulance | Own Trans. | Public Trans.
Date dd/mm/yyyy
Location | Unknown
Location Type: Home Residence | Healthcare Facility | Public/Commercial building | Nursing Home | Street/Highway | Industrial Place | Transport Centre | Place of Recreation | In EMS/Private Ambulance | Other, specify
Patient DOB dd/mm/yyyy | Age | Gender: Male | Female
Race: Chinese | Malay | Indian | Eurasian | Other, Specify
Medical History: No | Unknown | Heart Disease | Diabetes | Cancer | Hypertension | Renal Disease | Respiratory Diease | Hyperlipidaemia | Stroke | HIV | Other
Time call received by Dispatch (hh:mm:ss)
Time First Responder dispatched | No First Responder dispatched
Time Ambulance dispatched
Time First Responder arrived at scene | Estimated time of arrest (hh:mm:ss)
Time Ambulance arrived at scene
Time EMS arrived at patient side | Bystander CPR: Yes | No
Time ambulance left scene | Bystander AED: Yes | No
Time ambulance arrived at ED
Arrest witnessed by: Not witnessed | EMS/Private Ambulance | Bystander - Lay Person | Bystander - Family | Bystander - Healthcare Provider
First CPR Initiated By: No CPR | First Responder | Ambulance Crew | Bystander - Family | Bystander - Layperson | Unknown | Bystander - Healthcare Provider
Resuscitation attempted by EMS/Private Ambulance: Yes | No
First Arrest Rhythm: VF | VT | PEA | Asystole | Unknown shockable | Unknown unshockable | Unknown
Time CPR started by EMS/Private Ambulance (hh:mm:ss) | Unknown
Time AED applied by EMS/Private Ambulance | Unknown
Prehospital Defibrillation: Yes | No | Unknown
Time first shock given (hh:mm:ss)
Defibrillation performed by: First Responder | Ambulance Crew | Bystander - Lay Person | Bystander - Family | Bystander - Healthcare Provider
Mechanical CPR device used by EMS/Private Ambulance: Yes | No
If Yes, specify: Load-Distributing Band | Mechanical Piston/LUCAS | Active Compression-Decompression | Other
Prehospital advanced airway: Yes | No
If Yes, specify: Oral/Nasal ET | King Airway | Combitube | i-Gel Airway | LMA | Other
Prehospital drug administration: No | Yes, specify
Epinephrine | Lidocaine | Atropine | Dextrose | Amiodarone | Other | Bicarbonate
Return of Spontaneous Circulation at scene/enroute: Yes | No | Unknown
Time of ROSC (hh:mm:ss)
CPR discontinues at scene/enroute: Yes | No
If Yes, specify: Do Not Attempt Resuscitation (DNAR) | Return of Spontenious Circulation (ROSC) | Medical Control Order | Obvious signs of death | Protocol/polict requirements completed
Final status at scene: Conveyed to ED | Pronounced dead at scene
Cause of arrest: Trauma | Non-Trauma
If non-trauma, specify: Presumed cardiac | Respiratory | Electrocution | Drowning | Other
Level of destination hospital: Tertiary | Community
Destination Hospital: Specify
Patients Status at ED Arrival: ROSC | Ongoing Resuscitation | Transported without Resuscitation

After completing this form please inform the PAROS team by email: PAROS@nationalambulance.ae
This form must then be submitted with the PCR to your Area Manager at the earliest opportunity

Patient Medical Record - PCR
CGF160

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Version 2

4.6. MCI TRIAGE

Triage originates from the French word meaning 'sorting'. Triage is used by emergency crews during a Mass Casualty Incident (MCI) where they need to quickly sort through the casualties and prioritize between critical and non- critical patients. An MCI occurs when the number of patients outnumber the emergency resources available. It involves a massive team effort between different emergency response teams.
Simple Triage and Rapid Treatment (START) is used by the crews to evaluate the injured and assign them a color-coded tag according to their injuries:

RED: Life threatening "immediate intervention required". These patients must be transported first. These patients have a respiratory rate greater than 30 and are unable to respond or follow commands.

YELLOW: Delayed "early intervention required". These patients need to be transported but their injuries are not life threatening and they can afford to wait.

GREEN. Often referred to as *the walking wounded*. These patients have minor injuries and are the last patients to receive treatment. It's often advisable to ask these patients to walk to the treatment area so that there is better visual field for the rest of the patients.
RED/ BLUE CORNER – Expected to die (use only in exceptional circumstances with the agreement of MD)
BLACK: These patients are dead, or their injuries are so catastrophic that death is imminent. An attempt can be made to open the airway but if there is no respiratory effort with an open airway, the patient is tagged black.

For more detail please refer to OPP123 Major incident and disaster response policy and procedure

4.7. SUMMARY

Patient assessment, reassessment and triage along with knowledge of the Criteria Based Dispatch system are the essential components of a functional ambulance service; they are critical to your prompt and effective initial operational activity. If you are unclear regarding any aspect of this clinical Policy and Procedure you must discuss with your supervisor at the soonest opportunity

4.8. KEY POINTS

KEY POINTS

- Patient assessment should be commenced immediately after consent and access to patient is achieved
- Assessment to identify a working diagnosis to form the basis of your treatment plan
- Decisions made regarding patient treatment should be based on assessment findings
- You must document all your findings on the PCR
- If you are not able to carry out a required element of assessment record the reason
- Where more than one patient is present, Simple Triage and Rapid Treatment (START) is used
- START evaluates the injured and assigns them a color-coded tag according to their injuries
- Scene Survey, Primary assessment and Secondary assessment are all required elements
- Patient assessment information is used to enable the Criteria Based Dispatch system

5. RELEVANT LEGISLATION

International, federal or local legislation and circulars relevant to this Policy. Full detail on this legislation can be found in QHP109 Legal Register.

Code, Name of Legislation	Jurisdiction
Code, Name of Legislation, Year here	Jurisdiction here

6. RELATED POLICIES AND FORMS

List related policies and procedures to the created/updated policy.

Policy & Procedure /Form
CGP 105 Patient Consent Policy and Procedure
CGP 113 Patient Rights and Responsibilities Policy and Charter
CGP 115 Patient Transportation Policy & Procedure and
CGP 119 Patient Care Documentation and Patient Care Record Policy and Procedure
CGP 134 Patient Care Protocols

7. FEEDBACK

Any feedback or suggestions for improvement to this Policy, Processes or Procedures can be submitted to qhse@nationalambulance.ae

8. DOCUMENT CONTROL AND OWNERSHIP

A review and update of this document will take place as necessary, when changes occur that identify the need to revise this Policy such as changes in roles and responsibilities, release of new legislative or technical guidance, or identification of a new policy area.

This document ownership for editing is identified as:

- Medical Director

This controlled document is managed / overseen by Medical Director.

Change Brief

Version No.	Date	Change
1	05 December 2013	First Draft
2	12 April 2014	Revised to a policy and procedure, review against current PCR
3	18 May 2015	Addition of key points, clarity for recording patient observations
4	17 January 2016	Translation Project no changes
5	28 July 2016	Addition of points regarding PCR completion and compliance

6	October 2018	Assessment interval times Falls Assessment Assessment of patient mental status Assessment of patient emotional and behaviour status Reassessment (continuous) Medical Director Terminology
7	July 2021	Due for Review Update in the new format Update the roles & responsibilities (Rearrange, delete the word directors & supervisors) Add the role of the Clinical Governance & Audit Officer Remove word paramedic and add "Emergency Medical Technician (EMT)" in point 4.1 Add "(BGL) for all patient" in pony 4.4.2. Add CGP113 – Pain Management in point 4.5. Add the full name of "CGP119 – Patient Care Documentation and Patient Care Record Policy" in point 4.5. Delete the old copy of paper PCR Add the new copy of PCR (either electronic or paper) Delete word paramedics from point 4.6. Add the policy names to point 6 After Policy review committee June 2021 as per advised by Dr. Ayman to remove the section of triage and just refer - deleted section 4.7 triage dispatch - deleted the last section from 4.6 and the flowchart - add refer to OPP123 Major Incident and Disaster response Policy and Procedure

CEO Approval

Board Member Verification