



Clinical Practice Guidelines: Other/Standard cares

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Date	January, 2020
Purpose	To ensure a consistent approach to the provision of standard cares.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
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Every patient requires a measure of assessment and clinical deliberation to satisfy the paramedic's duty of care.

All CPG flowcharts within the CPM begin with 'Standard Cares', which refers to the continual gathering of clinical information, from vital signs and symptoms to a systematic clinical history and the analysis of this information.

Patient assessment

The standard QAS patient assessment includes a primary survey, an appropriate secondary survey and a well planned clinical history, with review and evaluation of all clinical information. This dynamic assessment should continue until the patient is transported to a suitable medical facility, or no longer requires assistance.

The primary survey is a rapid procedure designed to identify life-threatening conditions that require immediate intervention.

The secondary survey is a comprehensive compilation of clinical signs and symptoms, measured in combination with pertinent medical history such as discharge summaries and medical alert devices, which is the foundation of a detailed patient examination.

Patient assessment is not a singular event, but a continuous process that constantly considers and reevaluates clinical presentations.

Informed consent

Informed consent requires that the patient has a reasonable understanding of the examination, drug or procedure being performed/administered and the presence or absence of any risks. If the patient is unable to provide informed consent, that is, they are unconscious or in extremis, then consent can be assumed provided the examination, drug or procedure is required, conducted appropriately and is within the clinicians scope of practice.

Informed consent is required even if the patient does not speak English well, or at all, or has a disability that makes it difficult for them to understand the clinician or make themselves understood. Two resources that clinicians may consider using to facilitate communication with their patients are:

The translating and interpreting service – refer to *CPP Other/Translating and Interpreting service* and the *QAS Communication Board* – available in the Resources Section of this DCPM.

Prevention and management of pressure injuries

A pressure injury is an area of localised damage to skin and underlying tissue caused by pressure, shear or friction. While pressure injuries are more likely to affect older people and the frail, they can occur in patients of any age or state of health. Pressure injuries can lead to ulcer formation and life-threatening sepsis in the most severe cases.^[1]

Risk factors include:

- Patients with impaired mobility, including post-surgery.
- Patients who currently have or had a pressure injury in the past.
- Age over 65.
- Reduced sensory perception – e.g. diabetes, spinal cord injury, multiple sclerosis.
- Low BMI or obese.
- Weight loss/poor nutrition.
- Urinary and faecal incontinence.
- Underlying medical conditions that impair capillary perfusion, such as diabetes or peripheral vascular disease.
- Any person who cannot reposition themselves & lower limbs every 20–30 minutes.
- Excessively moist or dry skin.

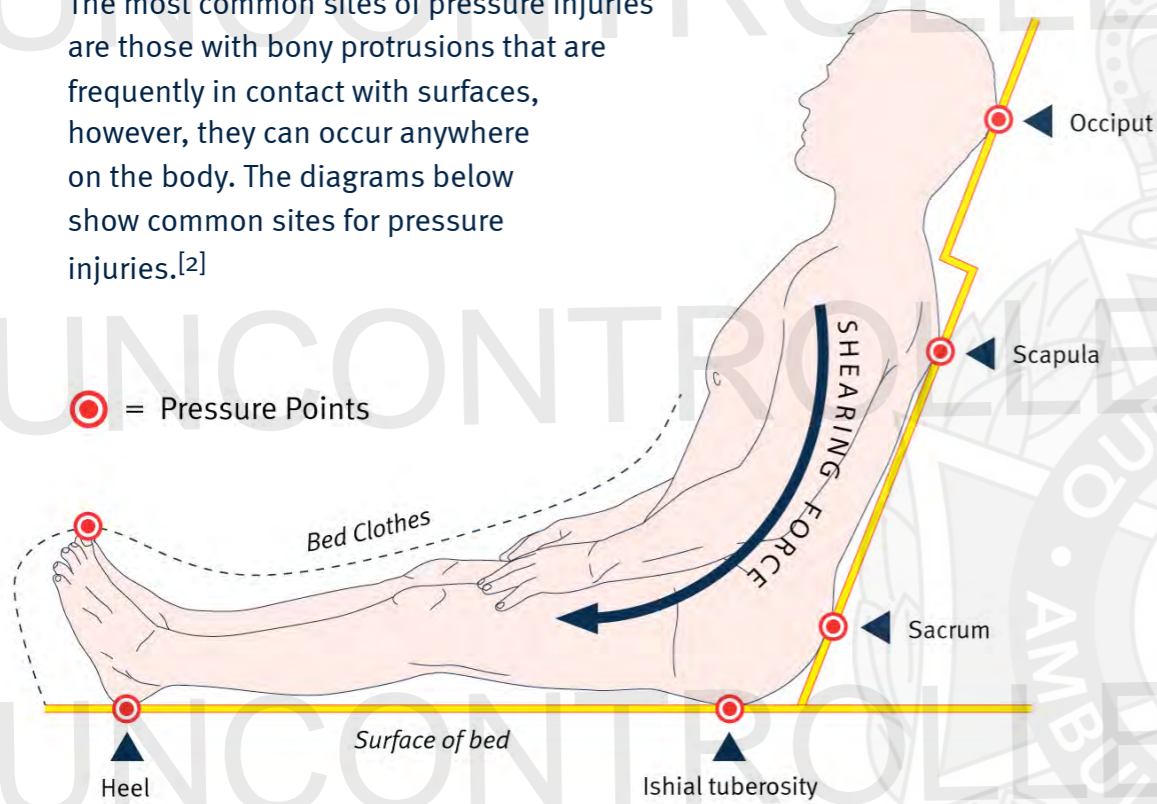


Paramedics should be vigilant to the possibility that their patient may have or be at risk of developing a pressure injury, especially for those patients having multiple risk factors.

Although the majority of patients are generally in our care for a short time, paramedics need to be cognisant that appropriate pressure injury identification, prevention and management improve the downstream care of the patient.

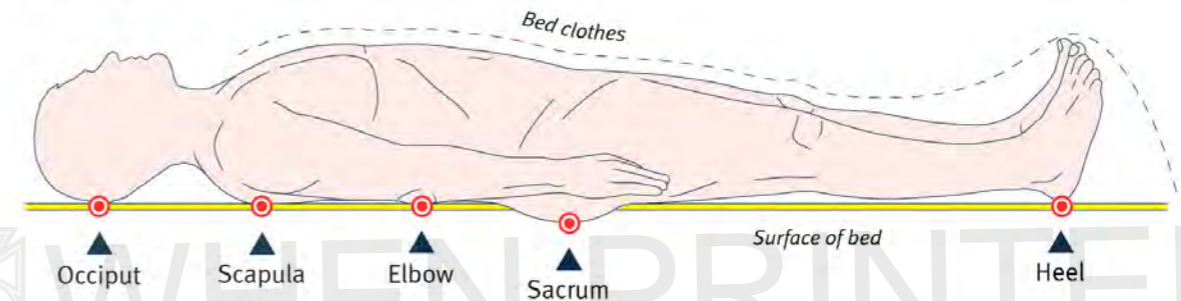
The most common sites of pressure injuries are those with bony protrusions that are frequently in contact with surfaces, however, they can occur anywhere on the body. The diagrams below show common sites for pressure injuries.^[2]

● = Pressure Points

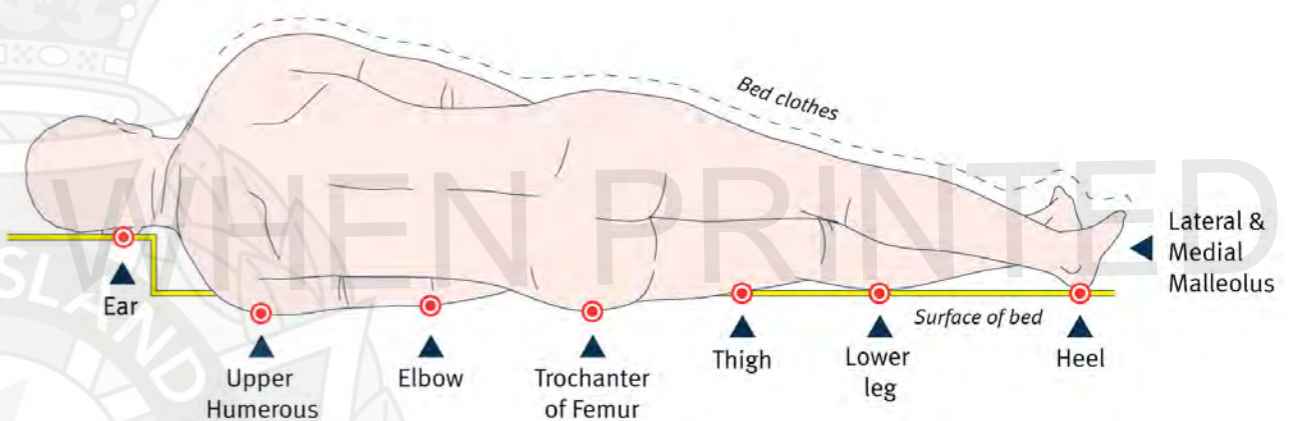


Patient in sitting position showing body contact points

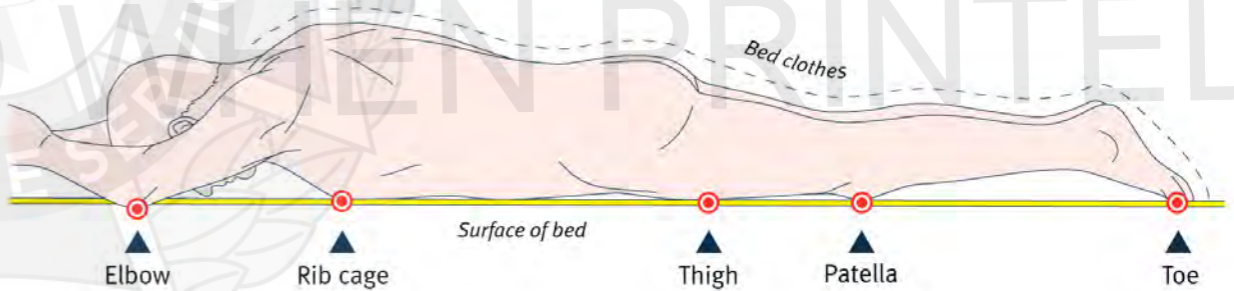
Supine position



Lateral position

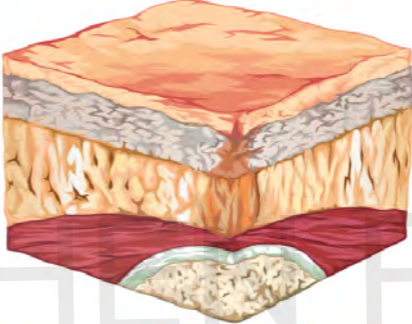
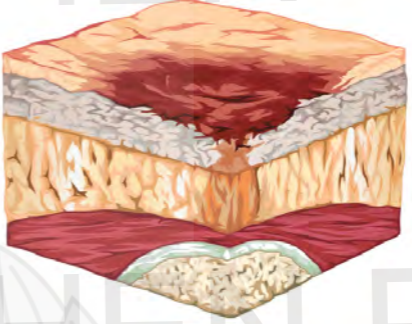
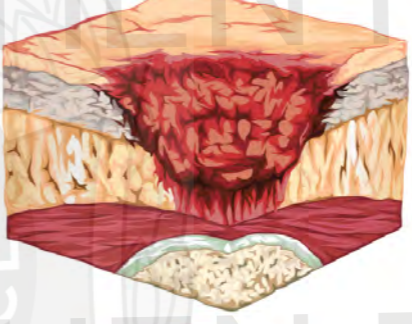
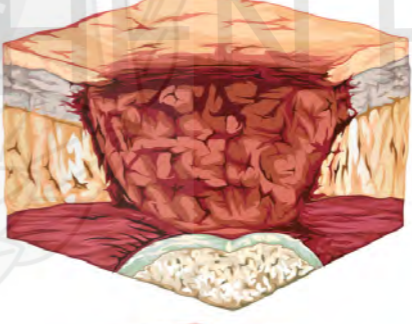
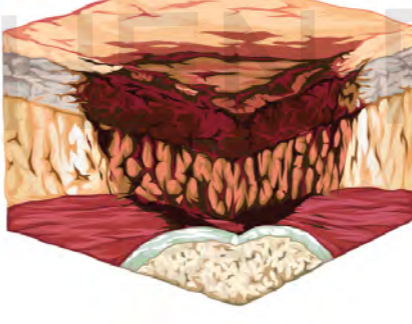


Prone position



Patient in lying position – supine, lateral and prone positions showing body contact points

Pressure injuries are most commonly graded into 4 stages of severity plus a fifth category for non-gradable.^[3]

<p>Stage 1 (superficial)</p>	<ul style="list-style-type: none"> • Skin intact but may be inflamed/red non-blanchable • Painful & warm to touch • Spongy or firm texture <p><i>N.B. Superficial pressure injuries can rapidly deteriorate into severe, life threatening deep tissue ulcers in patients who are not managed appropriately.</i></p>		<p>Stage 1 (superficial)</p>
<p>Stage 2</p>	<ul style="list-style-type: none"> • Skin broken, red and painful • Blistering, with/without ooze • No visible loose dead tissue • Tissue may be pale, red, swollen and warm 		<p>Stage 2</p>
<p>Stage 3</p>	<ul style="list-style-type: none"> • Skin ulcerated, extending to fat layer • May or may not be painful • White to black in colour, may be dead tissue • May have a foul smelling drainage 		<p>Stage 3</p>
<p>Stage 4</p>	<ul style="list-style-type: none"> • Full thickness ulcer extending to muscle, tendon or bone • White to black in colour • May be painful if bone is infected • Slough or eschar (dead tissue visible) • Foul smelling drainage possible 		<p>Stage 4</p>
<p>Stage 5</p>	<p><i>Non-gradable</i> – Dark skin / tissues that may be intact and conceal deep underlying tissue damage. Most common over the heel area.</p>		<p>Stage 5</p>

Practice points^[4]

- When clinically appropriate, ensure the patient's skin is clean and dry before positioning on the stretcher.
- Stretcher linen should be free of bumps, large folds or creases and should fit tightly on the mattress.
- Use approved manual tasking techniques to prevent injury to yourself or the patient when positioning the patient on the QAS stretcher.
- Before raising the head of the stretcher, move the patient up the stretcher and raise the knees. This will assist in avoiding shear from the patient slipping down the bed.
- Consider the use of support surfaces (e.g. soft pillow, hospital supplied medical grade sheepskin) to manage pressure load, shear, friction and microclimate.
 - Pillows will only be effective in offloading heel pressure when placed lengthwise under the lower limbs so heels are elevated and offloaded.
- Consider regular repositioning for patients unable to reposition themselves due to physical limitations.
- If appropriate, communicate to receiving clinical staff that the patient is at risk of pressure injuries and why.
- As part of their clinical assessment, ensure to examine for pressure areas and ensure all identified pressure areas are documented on the eARF (measurement of size and depth, exudate, odour and stage). Ensure medical staff and nursing staff are also notified.

Infection prevention and control

Frontline staff are reminded of the importance of ensuring compliance with the QAS Infection Control Framework hand hygiene principles to protect both themselves and our patients from infectious organisms. The most common way infections are spread between patients is via contact through the hands of health care workers.^[5] Appropriate hand hygiene practices by staff significantly reduce the rate of infections.

The five moments for hand hygiene at the point of care is the best way to promote the protection of our patients. Hand hygiene should be performed:

- Before touching a patient
- Before a procedure
- After a procedure or body fluid exposure risk
- After touching a patient
- After touching a patient's surroundings

To promote self-protection perform hand hygiene:

- If your hands are visibly soiled or have been contaminated by blood or body fluid
- If a patient is suspected to have *Clostridium difficile*
- After completing each case
- After using the toilet
- Before having a meal

Hand hygiene agents include

- Soap and water
- Alcohol based hand rubs
- Antimicrobial-impregnated wipes

Hand washing with soap and water is the best method of achieving hand hygiene when hands are visibly soiled. The rationale behind performing a procedural hand wash is to reduce the number of transient and resident flora on hands. If staff are not able to access hand washing facilities while out in the field they may use detergent wipes to remove organic matter and dirt. It is highly recommended that staff use hand wash facilities in preference to detergent wipes whenever it is possible.

If hands are not visibly soiled the preferred method for hand hygiene is to use alcohol-based hand rub, as this is the most effective method for reducing bacterial contamination on the hands and causes less skin irritation than soap and water.^[5]

Gloves are not a substitute for hand hygiene. Hand hygiene must be performed before donning and after removing gloves.

Transportation of patients' medications and/or valuables

All QAS staff are required to use the Tamper Evident bags to secure patient medications and valuables during transport. On arrival at the health service, the Tamper Evident bag must be handed over to the receiving facility staff.

If items require special storage (e.g. refrigerated medications, controlled drugs or valuables), the nursing staff are to be immediately advised.

To prevent confusion it is also advised that where possible the patient should also be informed of the current location of all medications and/or valuables at all times.

Transporting patients to private healthcare facilities

Where private healthcare facilities are available, patients should be offered a choice of public or private destinations. If the patient chooses a private facility the paramedic must call in advance to ensure the patient's condition can be adequately managed and patients must be advised that they are likely to incur out of pocket expenses.

For patients with serious illness or injury, primary consideration must be given to choosing the most appropriate destination for the patient's condition.

Transport considerations

The transport criticality of every patient must be carefully considered. Decisions around this concept depend on overall patient assessment and the level of pre-hospital clinical intervention available.

Interventions performed on scene must add value both in immediate patient care and to the overall patient care continuum.

Consideration should always be given towards transport to the most appropriate receiving facility depending on the patient's clinical presentation.

Additional information

- Effective teamwork and role allocation will facilitate assessments and interventions to be conducted simultaneously.
- Often a definitive diagnosis can not be established in the pre-hospital setting. A paramedic's provisional diagnosis provides a treatment plan, which is not fixed and should be altered in accordance with variations or trends in patient presentation.
- A paramedic's clinical judgement and experience, in conjunction with concepts of patient assessment, will determine what is critical in immediate management, and what intervention is required.

Manage as per:
Relevant resuscitation CPG

CPG: Clinician safety
CPG: Standard cares

Signs of life?

Life-threatening circulatory, airway or breathing compromise?

Manage as per:
Relevant CPG

Within normal limits?

Abnormalities found?

EVALUATE VITAL SIGNS:

- GCS
- Colour
- Pulse rate/rhythm
- Blood pressure
- Respiratory rate and effort
- Auscultate
- Pupillary response
- ECG
- Blood glucose level
- Pulse oximetry
- Temperature

Consider:

- Patient's medical history
- Nil by mouth

Note: Clinicians are only to perform procedures for which they have received specific training and authorisation by the QAS.

CONDUCT HEAD TO TOE ASSESSMENT. LOOK AND FEEL FOR:

- Bleeding
- Deformities
- Loss of sensation
- Disability
- Oedema
- Subcutaneous emphysema
- Skin turgor
- Medical alerts