Clinical Notice

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

To:	**All Clinical Staff**
Date:	**28 October 2020**
Document Number:	**CN/436**

Pre-alerting of Patients

The Association of Ambulance Chief Executives (AACE) and The Royal College of Emergency Medicine (RCEM) have released UK NHS Ambulance Services pre-alert guidelines for the deteriorating adult patient, using this the Trust has issued guidance on pre-alerting patients.

A pre-alert call from an ambulance clinician to a receiving hospital should be used to provide information about the patient that will enable the receiving Emergency Department or other clinical area to prepare a different or special response.

The purpose of the pre-alert call is to allow time for the receiving hospital to:

- Prepare to provide immediate clinical interventions
- Support patient or staff safety
- Activate a specific clinical pathway that is required immediately on the patient's arrival.

Pre-alert calls must only be made when, in the view of the ambulance clinician, the patient's condition requires such a response. They should be made according to the following criteria:

Criteria

- Physiological: Altered physiology (values here are for adults, for paediatric values see JRCALC page for age) including any of the following:
- Respiratory rate ≤8 or ≥25
- O2 saturations on oxygen <92% (Patients usually running normal oxygen saturations) <84% (Patients with chronic hypercapnic respiratory failure)
- Systolic <90mmHg OR downward-trending systolic where symptomatic
- Tachycardia ≥131

OR

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Specific conditions

- Cardiac/Respiratory arrest
- Airway compromise
- Major trauma tool positive
- ST elevation MI
- Complete heart block or broad complex tachycardia with adverse features (shock, syncope, heart failure, myocardial ischaemia)
- FAST-positive stroke within timeframe for thrombolysis
- Sepsis with red flags triggering the Sepsis Trust prehospital bundle
- Uncontrolled seizure (still fitting)
- Obstetric emergency e.g. maternal convulsions, shoulder dystocia or abnormal presentation of the baby
- Life threatening asthma
- Uncontrolled major haemorrhage
- Unconscious with a GCS motor score of less than 4
- Overdose with abnormal physiology and possible lethality, which may require immediate intervention on arrival
- Unstable vascular emergencies with clinical shock (e.g. AAA, thoracic dissection) or acutely ischaemic limb
- A locally agreed emergency pathway may need to be triggered by a specific pre-alert

A pre-alert can also be made for any rapidly deteriorating patient where an ambulance clinician is concerned for reasons other than the specific criteria highlighted in this guideline.

Medical Alerts including paediatrics and obstetrics

- The pre-alert should be made directly by the ambulance clinician to the receiving hospital utilising the ARP system. The Emergency Operations Centre (EOC) should not be used to make a third-party pre-alert call on behalf of the attending clinician.
- The alert should be made as soon as possible to allow for the maximum amount of time available for the receiving unit to prepare for arrival of the patient.
- An estimated time of arrival e.g. 1400 hours must be used rather than an estimated value time e.g. 10 minutes. This is so that as messages are passed there is a consistent time of arrival.

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Major Trauma Patients and Silver Trauma Patients

- Where a patient triggers either the Major Trauma Tool or the Silver Trauma Tool then the Regional Trauma Desk (RTD) must be contacted either by ARP on talk group 282 or on 01384 215695.
- An ATMIST structured approach should be used to communicate with the RTD.
- An estimated time of arrival e.g. 1400 hours must be used rather than an estimated value time e.g. 10 minutes. This is so that as messages are passed there is a consistent time of arrival.
- The RTD will then facilitate the onward pre-alert call to the receiving hospital.

Structure of Alert Information

A pre-alert call must be clear and concise (ideally no more than 60 seconds) and it must follow the structured format ATMIST for both medical and trauma alerts:

Age	Age and sex of casualty (demographic)
Time	Estimated time of arrival Time of onset of symptoms Time of the incident
Mechanism of Injury **M**edical Complaint	Mechanism of injury. This should include: • The gross mechanism of injury (e.g. motor vehicle crash or stab wound to the chest) and, • Details of other factors known to be associated with major injuries e.g. entrapment, vehicle rollover, occupant ejected from vehicle. Medical complaint. This should include: • General impression/ working diagnosis • Primary survey
Injuries **I**nformation related to complaint	Injuries: seen or suspected. Information related to complaint: • History • Applicable system assessment
Signs	• Vital signs including heart rate, blood pressure, respiratory rate, oxygen saturation, Glasgow Coma Score and ECG findings if applicable. • An indication as to whether the physiological state of the patient has improved or deteriorated since first seen.
Treatment	Treatment given

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Review Date: October 2021