



Clinical Practice Guidelines: Other/Standard cares

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Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
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Every patient requires a measure of assessment and clinical deliberation to satisfy the clinician'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.

iPhone and Android mobile phone users often have a Medical ID which lists the user's clinical details such as medical conditions, allergies, and other relevant information, in case of a medical emergency.

This is usually accessible from the device's Locked Screen and clinicians should ensure they check personal devices, especially in cases where there are no other sources of the patient's medical history available to them, e.g., the unaccompanied unconscious patient.

Patient assessment is not a singular event, but a continual 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 clinician's 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:

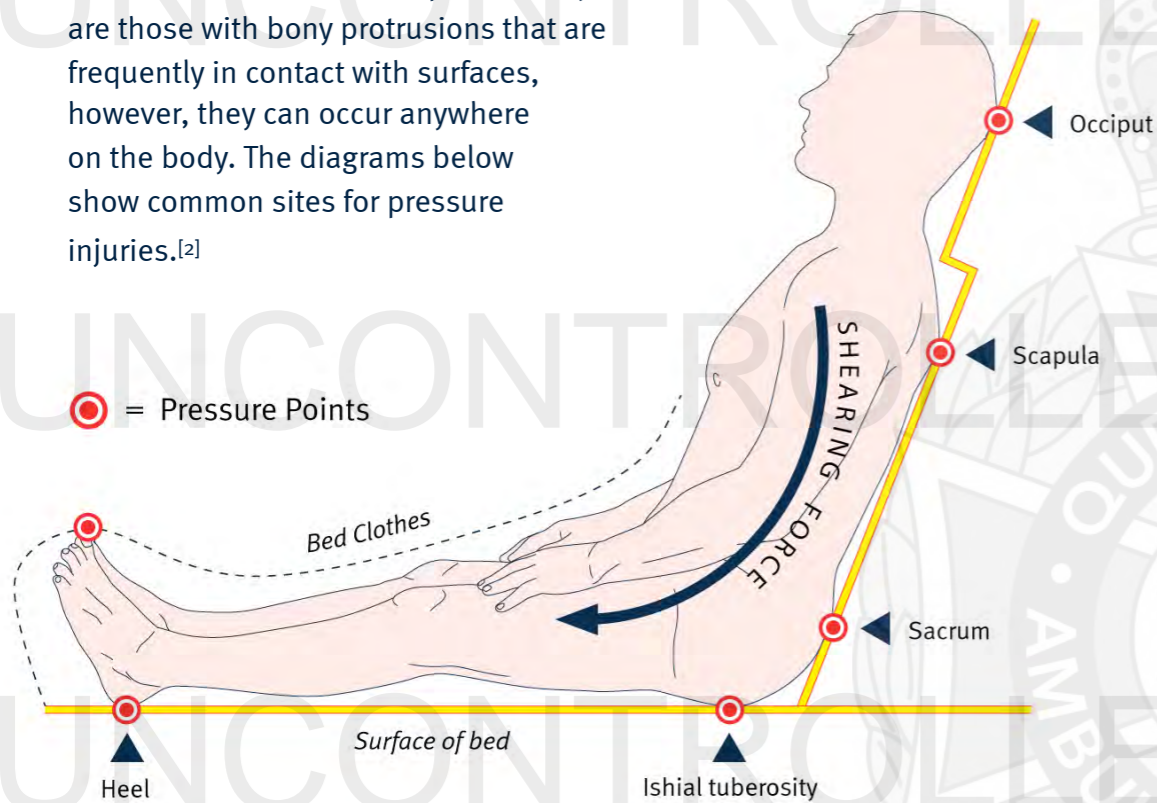
- Patients with impaired mobility, including post-surgery.
- Patients who currently have or had a pressure injury in the past.
- Age over 65.
- Reduced sensory perception – e.g. diabetes, spinal cord injury, multiple sclerosis.
- Low BMI or obese.
- Weight loss/poor nutrition.
- Urinary and faecal incontinence.
- 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.

Clinicians 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, clinicians need to be cognisant that appropriate pressure injury identification, prevention and management improve the downstream care of the patient.

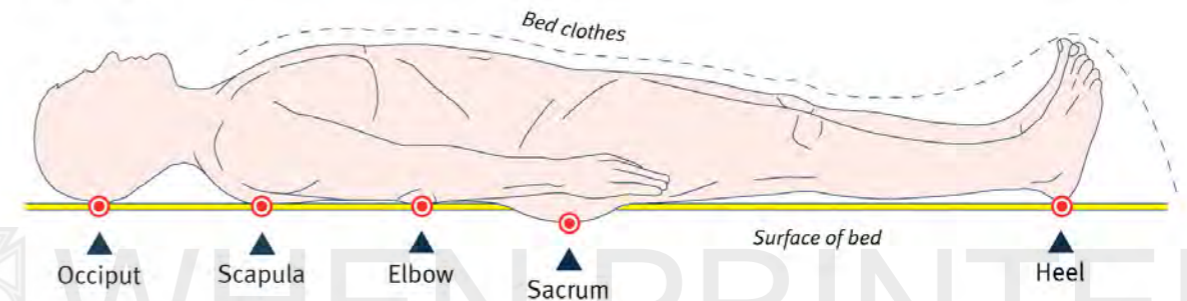
The most common sites of pressure injuries are those with bony protrusions that are frequently in contact with surfaces, however, they can occur anywhere on the body. The diagrams below show common sites for pressure injuries.^[2]

● = Pressure Points

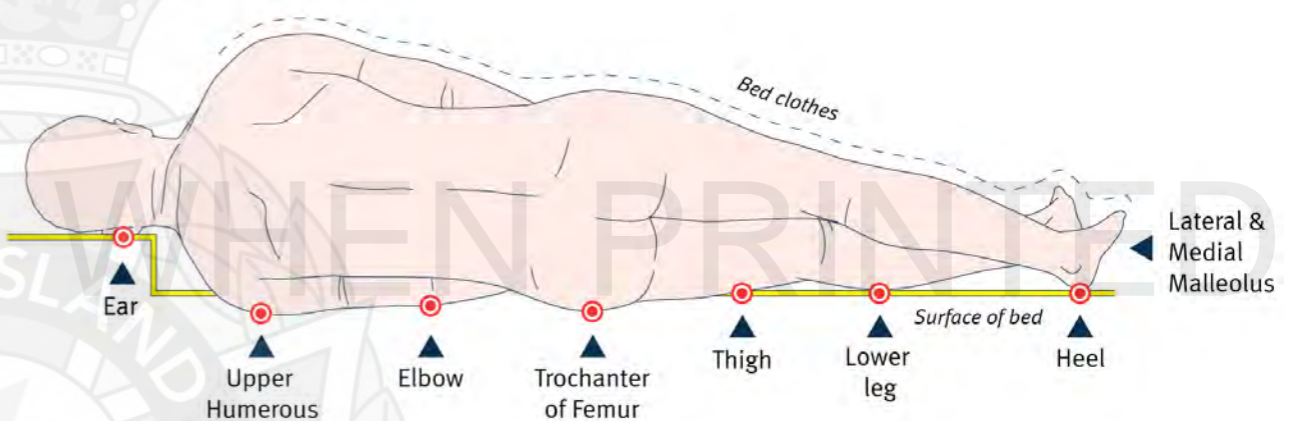


Patient in sitting position showing body contact points

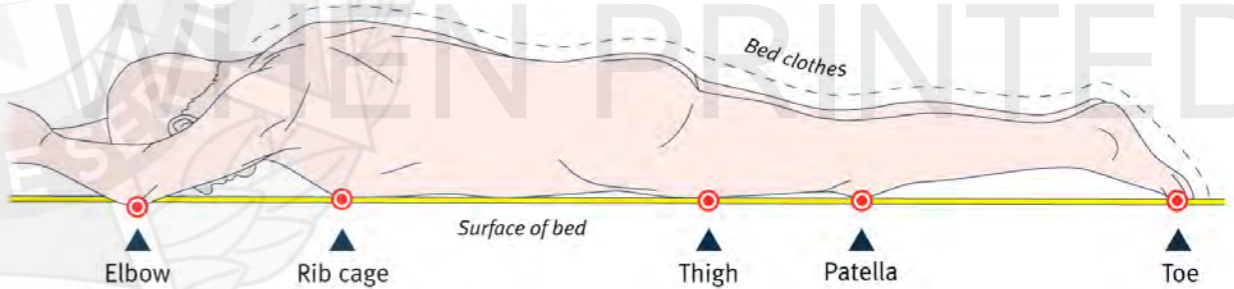
Supine position



Lateral position

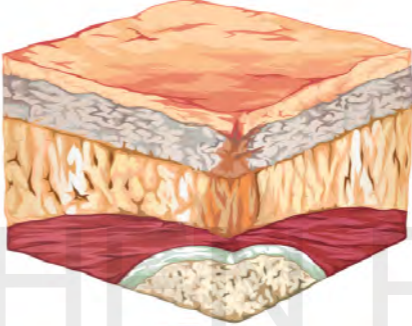
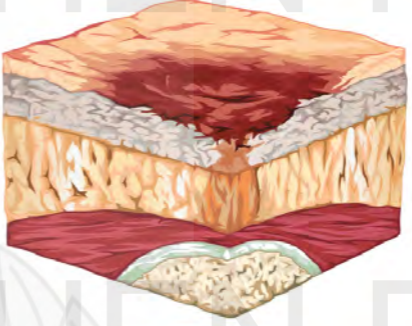
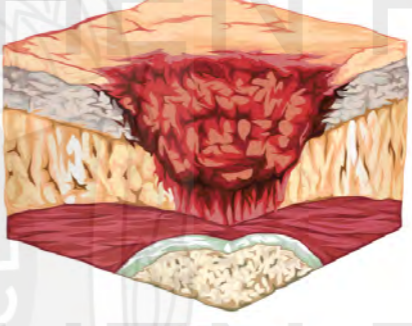
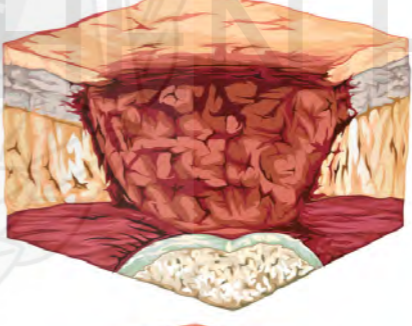
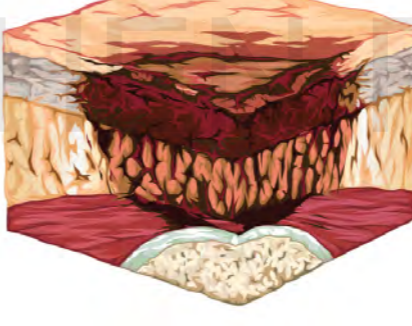


Prone position



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.

Patient Mobility Risk Assessment

To determine the most appropriate and efficient way to transfer patients from one location to another, clinicians should undertake a Patient Mobility Risk Assessment (PMRA) and then develop and communicate a transfer action plan.

Undertaking a PMRA will assist the clinician to:

- Improve patient care and safety
- Prevent accidents
- Prevent unnecessary lifting of patients who are capable of self-mobilising
- Determine what, if any, lifting or transfer equipment is the most appropriate for the situation
- Minimise the risk of injury to QAS clinicians and others

A PMRA should be performed for all patients (when practical), cognisant of the patient's conditions and risk of exacerbating the patient's injury or illness.

Patients who are able to self-mobilise should be encouraged to do so whenever possible, however, clinicians must exercise clinical judgement in deciding whether it is safe and clinically appropriate to allow a patient to self-mobilise, even if they are physically capable of doing so, by taking into account the patient's current clinical condition.

Clinicians should have a low threshold for requesting additional resources for assistance with lifting and extrication when potential safety or injury risks are identified.

All QAS employees must familiarise themselves with the relevant WHS Hazard and Risk Management policies and guidelines that can be found on the [QAS Portal](#).

Detailed instructions on how to conduct a PMRA form part of the Manual Tasking Education Program package which is accessible by logging onto QAS Continuous Learning Online (QASCLO) through the [QAS Portal](#).

Transport 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 must 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 clinician 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.

Observation and supervision of patients during ambulance transport

All patients transported by QAS must be appropriately supervised at all times for the entire duration of the transport and while in QAS care.

When transporting a patient as part of a multi-officer crew, it is expected that one ambulance clinician travel in the rear of the vehicle to appropriately observe and supervise the patient in their care at all times. This applies to all patients regardless of their degree of acuity, reason for transport, or whether they are seated or on a stretcher, including Patient Transport Service operations. In instances when there are observers or university students on placement present, a supervising officer must always remain in the rear of the vehicle.

Ambulance clinicians working as a single officer must conduct a risk assessment based on the clinical status and other circumstances of the case. In QAS vehicles fitted with internal CCTV, the single officer is required to use the system to maintain visual contact of the patient at all times during transport.

If presented with any challenging situations, officers should contact their respective Operational Supervisor to seek advice on how safety can be maintained for both themselves and the patient.

Post-triage responsibilities

In instances where there are delays in offloading a patient at a healthcare facility, ambulance clinicians have a continuing responsibility to ensure patient safety. While the overall primacy of care transitions to the healthcare facility upon triage, this does not absolve the ambulance clinicians duty of care to the patient. Broadly, the following principles must be adhered to while awaiting offload:

- Regular, thorough and appropriate clinical observations must be undertaken and subsequently recorded within clinical documentation.
- If changes or deterioration in the patients clinical presentation are observed, hospital staff must be immediately notified. In such instances it is incumbent of the ambulance clinician to take appropriate action in accordance with existing clinical guidelines and/or procedures.
- The administration of medications or provision of other clinical interventions are to be undertaken if clinically required. Note, where possible this should occur in consultation and collaboration with medical/nursing staff.
- The physical needs and personal cares of patients must be closely monitored. This includes holistic cares such as the prevention of pressure related injuries, toiletry requirements and ensuring access to food and water (if appropriate).

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 clinician'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 clinician'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.

