CSOP No. 023

Title: Emergency Department Handover

Version 3.4 Effective Date: 22/11/2022

APPROVALS

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Next Review Date:	November 2024		

HISTORY

Effective Date	Version No.	Summary of Amendment
19/10/12	2.0	Time of injury added.
19/10/12	3.0	Updated into new format + added Appendix 1
01/11/14	3.1	Reviewed, minor rewording changes
Feb 2017	3.2	Review
April 2020	3.3	Reviewed, no changes required
Nov 2022	3.4	Amend to 3.4 regarding printing of ePR

REFERENCES

Document Reference Number	Document Title

1. Purpose

This CSOP provides guidance on a formal format for the handover of patients to Emergency Department staff

Title: Emergency Department Handover

Version 3.4 Effective Date: 22/11/2022

2. Definitions/Acronyms

Abbreviations	Definitions
CSOP	Clinical Standard Operating Procedure
BP	Blood Pressure
GCS	Glasgow Coma Scale
BM	Blood Glucose
ECG	Electrocardiogram

3. Scope

3.1 Format

The handover should be based on the ATMIST mnemonic and include the following information:

For a trauma patient:

- **A**ge (name & Sex)
- **T**ime of incident and time trapped
- **M**echanism of Injury
- **I**njuries suspected
- **S**igns (Pulse, BP, GCS, Vital signs, moving all 4 limbs
- **T**reatment administered & immediate priorities e.g. Massive Transfusion Protocol

For a medical patient:

- **A**ge (name & Sex)
- **T**ime of onset of symptoms
- **M**edical presenting complaint and suspected diagnosis
- **I**nvestigations e.g. BM, ECG
- **S**igns in ABCD format
- **T**reatment & interventions

Title: Emergency Department Handover

Version 3.4 Effective Date: 22/11/2022

3.2 Pre-handover

Before arriving in the emergency department the team should prepare their handover. The handover will be delivered by the HEMS crew member responsible for the patient's care. The verbal handover should start after the patient has been moved into the cubicle unless the patient has time critical immediate issues that need addressing. In such cases a HEMS crew member could go ahead to highlight these issues.

3.3 During Handover

The crew member handing over should inform the trauma team leader if the patient requires any emergency intervention prior to the full handover being given. All members of the trauma team should be able to hear the handover. No interventions should be performed during the handover with the exception of a cardiac arrest (ventilation and chest compressions) or a ventilated patient (ventilation by the airway doctor).

3.4 Post Handover

Lead clinician responsibilities

- Complete full documentation
- Obtain team handover signature for PRF unless ePRF used
- Provide print out of monitor observations with annotations for erroneous readings/key interventions and hand to trauma team leader
- Ask team leader if they have any questions before leaving. In the RSI patient, also ensure the anaesthetist has any additional information they require.

Second team member responsibilities

- Ensure staff have immediate information to register the patient
- Assist emergency department staff with removal of pre-hospital equipment.
- Retrieve all equipment.
- Liaison with pilot/land crew
- Liaison with ambulance control

Title: Emergency Department Handover

Version 3.4 Effective Date: 22/11/2022

Pilot responsibilities

- Providing doctor/paramedic with scene times
- Remind crew of available fuel and flying times prior to booking available
- Alert security of hospital for take-off time (if applicable)

All crew members should work as a team to ensure the HEMS crew and aircraft are available as soon as possible for re-tasking or to return to base for restocking/debriefing.

3.5 Going "Green"

The paramedic, doctor and pilot will liaise prior to becoming available for future jobs. Considerations include:

- Equipment- is it sufficient for another job?
- Fuel
- CRM issues- are there any difficult jobs or critical incidents that require debrief or discussion with the Head/Director of Operations, Clinical Lead or Clinical Supervisor prior to resuming duty?

Where the aircraft has landed at a secondary site it may be appropriate, following liaison with the pilot, to inform control whilst the crew are travelling back that the aircraft will be available once they arrive at the secondary site.

Example of handovers

For a trauma patient:

- This is David, 22 year old male
- Incident occurred at approximately 1400
- RTC driver of car wearing seatbelt, T boned on drivers side by car traveling 40mph, he was environmentally trapped for 40 minutes
- Injuries top to toe are abrasion to his right parietal region, tenderness right lower ribs, good air entry both sides of chest, tender right lateral abdomen
- Complaining of some abdominal pain. Tachycardic at 120bpm throughout but BP >120 systolic. Sa02 100% on 15 L Oxygen. GCS on arrival was 15. Moving all 4 limbs.

Title: Emergency Department Handover

Version 3.4 Effective Date: 22/11/2022

- Treatment so far -IV access in Right ACF- crew had given 10mg morphine, we gave 35mg of Ketamine to facilitate extrication, a pelvic binder has been applied due to mechanism.

For a medical patient:

- This is Ethel a 75 year old female
- At 1000 she developed chest pain, starting at rest
  - The pain is described as heavy, associated with nausea, likely acute coronary syndrome
  - ECG shows gross ST depression in anterolateral leads
- Bilateral basal creps on chest examination, Sa02 were 96% on air, BP 210/88 and pulse 90
- Treatment so far: 300mg Aspirin, 2mg GTN buccal, IV access left hand, 7mg IV morphine

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