Midlands Air Ambulance

(In partnership with West Midlands Ambulance Service NHS Foundation Trust)

Standard Operating Procedure

Aircraft call-out guidelines – Dispatch criteria

DATE APPROVED:	**November 2016**
APPROVED BY:	**Air Operations/RTD/MERIT Manager**
IMPLEMENTATION DATE:	**November 2016**
REVIEW DATE:	**November 2018**
LEAD DIRECTOR:	**WMAS Director of Specialist Operations**
IMPACT ASSESSMENT STATEMENT:	

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Change Control:

Document Number	OPS-SOP-002
Document	**Standard Operating Procedure 'Aircraft call-out guidelines – Dispatch criteria'**
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Impact assessment	
Author	Air Operations Manager / Airdesk Teamleader

Change History:

Date	Change	Authorised by
31/01/2010	Re-draft	R Tinsley
03.02.10	Review by Midlands Air Ambulance Operational and Clinical governance focus group – Amendments include: - 3.4.3 – Explanation of upgrading from air ambulance to HEMS - 4.2 – Response of RRVs alone is unacceptable - Minor grammatical errors	
10.02.10	Amendments to format by GSR Manager	
13.02.10	Sent to MW – Regional Head of Clinical Services for comments regarding Fast positive and PCI	
16.02.10	Amendments by Regional Head of Clinical Services 3.3.1 – CVE to read Stroke 6.4.4 Change from 'Is the arrival of the air ambulance likely to be sooner than the arrival time at the most appropriate centre for care if transport is started now?' to be amended to 'The air ambulance should only be stood down if the patient can reach a centre for definitive care by land sooner than by air.'	
19.02.10	Sent to WMAS Clinical Governance Committee (CGC) for comment, by Governance, Safety & Risk Manager	

Date	Change	Authorised by

19.02.10	Comments from WMAS CGC: 1. Appendix 1 'Interrogation of calls' – Should check to ensure not repetition of questions already being asked on AMPDS 2. Audit proposal to be submitted as soon as approved to check effectiveness 3. Needs to be reviewed by Executive Manager Board	
20.02.10	Amendments made by Regional Head of EOC (Jeremy Brown) 3.1 HEMS Dispatch criteria – Did read ' Interrogate the following calls' – Now reads 'Immediate dispatch but interrogate the following calls for confirmed suitability'	
24.02.10	Governance, Safety & Risk Managers assessed against 'Framework for a High Performing Air Ambulance Service – Compliance Document'	
24.02.10	Orange action boxes labelled 'Delayed dispatch – within 7 minutes' changed to 'Immediate dispatch – but may be appropriate for further interrogation' – Boxes changed to red	Air Operations Manager
31.03.10	Reviewed at Operational Management Sub-Committee. Action note 9.2.1 records 'SOP has been sent to Senior Operational Manager. There has been no objections received, so RT to formally approve"	Air Operations Manager
06.05.10	3.1 Hems Dispatch Criteria - Did read 'Immediate Dispatch but Interrogate the following calls for confirmed suitability' – now reads Interrogate the following calls.	Air Operations Manager
06.05.10	Red action boxes labelled Immediate Dispatch changed to Orange and labelled Delayed Dispatch – within 7 minutes	Air Operations Manager
06.05.10	Falls <20ft or 2 storeys added to Interrogate the following calls list.	
07.0510	Change of dispatch discussed at Midlands Air Ambulance Charity Governance Committee. All agreed to change with an audit proposal to be submitted. For review September 2010	
07.05.10	Forwarded to the Specialist Operations Manager for final approval and 'go live date'	
07.05.10	Approved by Specialist Operations Manager	S Wheaton
28.11.10	Reviewed and amended by Air Operations Manager 3.1 amendment to interrogation of select calls, added to delayed dispatch that if no further information available within 7 minutes	

	of 999 call revert to immediate. 5.4 added .	
28.11.10	Sent to clinical lead and Regional Head of Specialist Operations for Review	
13.12.10	Approved	R Tinsley
April 2010	Reviewed by Regional Head of Specialist Operations	
April 2011	Reviewed by Clinical and Operational Lead WNAA 1.2 added Warwickshire and Northamptonshire Air Ambulance 5.4 Any clarification may be discussed with the Regional Head of Specialist Operations and Air Operations Manager, Midlands Air Ambulance Clinical Lead for Midlands Air Ambulance and/or for WNAA the Operations Director or WNAA Medical Director.	Air Operations Manager
May 11	Review of amendments by Regional Head of Specialist Operations, WNAA Operations and Clinical Lead	
June 11	No further feedback received from WNAA	
June 11	Final review, approval and distribution	R Tinsley
Nov 11	Review requested by AOM from Airdesk Supervisors, Clinical/Operational Leads,	R Tinsley
Dec 11	Dispatch Criteria flowchart 3.1 – Immediate dispatch changed to read Within 3 minutes of call being triaged or notes added	
Dec 11	Delayed Dispatch changed to read Within 7 minutes of call being triaged, notes added or crew request *	
Jan 12	Reviewed by the Clinical and Operations Committee	
Feb 12	Reviewed by AOM	
March 12	Approved and distributed	AOM
March 2013	Following RCA 2012-20814 Special Considerations: 5.5 consider travel and load time of Helimed when requesting their presence for rapid transportation to ensure patients admission times are not prolonged	R Tinsley
April 2013	Sent to MAA Clinical Lead WNAA Head of Specialist Operations MAA Clinical Leads Airdesk Supervisor	
April 2012	Amendments WNAA	

	1.2 – add part of Warwickshire to reflect tasking from EMAS 3.2.1 add CCP 5.4 add Clinical Services Training Manager	
April 2012	Head of Specialist Operations amendments: 1.2 added supported by the RTD	
May 2013	Amendment received from Airdesk Supervisor: 3.1 Add confirmed to immediate dispatch for train/plane/coach incidents 3.1 add to interrogated cardiac arrest ‘’if no resource available within 8 minutes of call triage end’’ 3.1 word change instead of call connect to call triage ended 3.1 The RTD paramedic will provide clinical input to support the decision making process and ‘call back’ to assist in the decision making to dispatch an aircraft/team based on the patients clinical condition	
June 2013	Final review by Head of Specialist Operations	
June 2013	Reviewed, approved and distributed	AOM
October 2014	Reviewed by Clinical/Ops committee Change History: 2.3 added RTD requested Dispatch 3.2 RTD Call back	
May 2015	Approved by Director of Specialist Operations	
July 2015	Added Air Ambulance Service logo + TAAS to 1.2	
July 2015	Reviewed, approved and distributed	R Tinsley
August 2016	Airdesk for review: Amends from EOC include: 3.1 Severe burns (confirmed) added to immediate dispatch criteria 3.1 Stabbing (central body) added to immediate dispatch 3.1 Shooting (central body) added to immediate dispatch 3.1 Stabbing (unconfirmed area) added to interrogated dispatch 3.1 Shooting (unconfirmed area) added to interrogated dispatch 3.1 Burns (peripheral / unconfirmed body area) added to interrogated dispatch 3.1 Chest pain in remote area added to	J Round

	interrogated dispatch	
September 2016	Reviewed by TAAS, BS and Mark Nash	
November	Final review, approval, distribution	R Steele

CONTENTS

APPENDICES

1 INTRODUCTION

1.1 Appropriate tasking of the aircraft is an important factor in the success of Helicopter Emergency Medical Services (HEMS) operations. Successful aircraft tasking is dependant upon selecting the right cases, arriving in a timely manner and delivering advanced interventions to the patients with transportation to the most appropriate receiving hospital. Any break in the chain will result in the failure of tasking with potentially serious implications for both the patient and HEMS organisations.

1.2 Midlands Air Ambulance Charity (MAAC) and The Air Ambulance Service (TAAS) tasking is dealt with autonomously in the WMAS region by a dedicated HEMS dispatch team located within WMAS EOC who have completed a Babcock MCS HEMS dispatch course. The dispatch team is also closely supported by a Specialist Trauma Paramedic attached to the Regional Trauma Desk (RTD).

2 TASKING RESPONSIBILITIES

2.1 Daily tasking responsibilities in the dispatch phase should include:

2.2 Dedicated Air Desk Team

2.2.1 Identifying an incident against an agreed dispatch criteria

2.2.2 Identifying the classification for dispatch (HEMS or Air Ambulance)

2.2.3 Identifying the availability of air ambulance assets

2.2.4 Balance dispatch against other assets known to be deployed

2.3 RTD Requested Dispatch

2.3.1 Immediate dispatch of HEMS/MERIT on request of the Regional Trauma Desk (RTD) Critical Care Paramedic (CCP) when the initial call does not meet the immediate dispatch criteria used by the Airdesk based on clinical information available.

2.3.2 If possible the need for dispatch will be identified via interrogation of the initial 999 caller using a set call back procedure

2.3.3 If interrogation of the 999 caller is not possible or the call originated from another service immediate dispatch can be requested by the RTD CCP based on their clinical knowledge, experience and interpretation of the call

2.4 Operators / Pilots

2.4.1 Legality of flight and passengers

2.4.2 Serviceability of aircraft

2.4.3 Limitation of weather

2.4.4 Pilot duty hours and discretionary options

2.4.5 Endurance of the aircraft

2.4.6 For inter hospital transfers availability and serviceability of landing facilities at destination

2.5 Aircrew

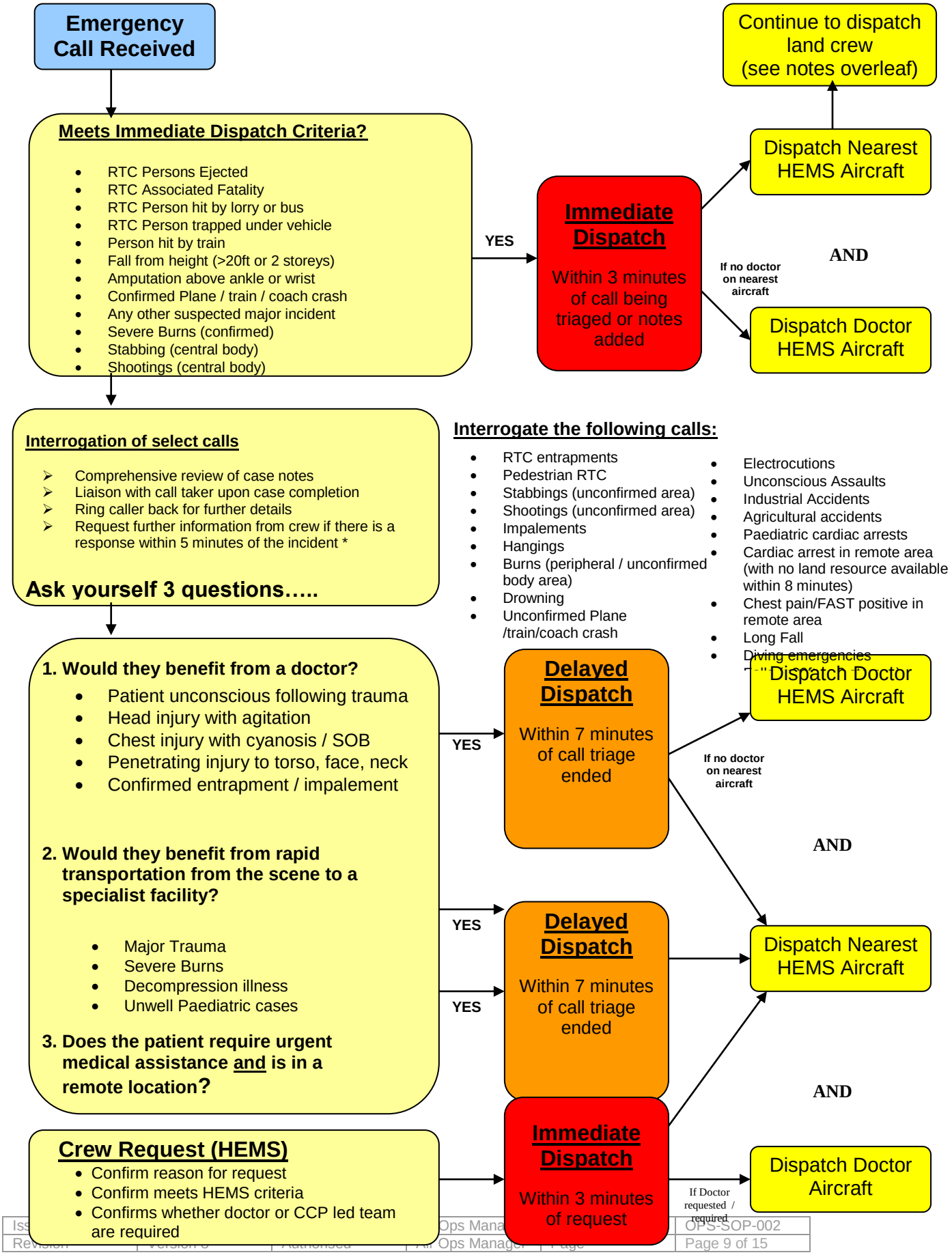
2.5.1 Confirmation of incident classification based on medical information

2.5.2 Medical benefit able to be brought to the patient (both by crew and by destination hospital options)

2.5.3 Serviceability of medical equipment on the aircraft

3 DISPATCH

3.1 HEMS Dispatch criteria



- The aim should be to reliably respond an aircraft to an appropriate incident within 7 minutes of call triage. If the category meets an aircraft response criteria and no further information is obtained within 7 minutes, the incident should revert to an immediate dispatch to avoid any unnecessary delays.

- The RTD CCP will provide clinical input to support the decision making process and 'call back' to assist in ensuring the dispatch of an aircraft/team is based on the patients clinical condition.

- The RTD CCP can override the dispatch protocol if they see clinical benefit for the response of enhanced clinical teams (CCP/DR) by air/car that may fall outside of the normal decision making process. This must be managed in conjunction with the airdesk duty team. The relevant skill mix should be considered for all tasking (CCP and/or Dr led responses).

- * if the dispatch falls within call interrogation, an update may be requested from a responding vehicle if within 5 minutes of the incident. It is not acceptable to wait more than 7 minutes for further information.

3.2 RTD Call Back

3.2.1 The types of call that may be interrogated by the RTD CCP are listed in the HEMS dispatch criteria. The list is not exclusive and anything that appears serious should be interrogated.

3.2.2 Appendix 1 outlines a set of questions that may assist the RTD CCP when using call-back. These questions can be adapted appropriately by the CCP in order for them to gain the best possible mental picture of the scene

3.2.3 When interrogating callers, consideration must be made for the fact that they may be distressed, confused, angry or frightened. Give reassurance that help is on its way.

3.2.4 If the 999 caller has medical training questions can be altered appropriately. For example, asking about GCS, signs of shock etc

3.2.5 Any notes relevant to the call must be entered onto the call log

3.3 Crew Requests

3.3.1 Crew requests should be classified as either HEMS requests or Air Ambulance requests. To meet HEMS criteria the case must warrant:

- Rapid transportation of a medical team to the scene to deliver urgent care.

(I.e. bring a doctor/CCP to augment paramedic care, or paramedic to augment tech care)

- Rapid transportation of the patient from the scene to a specialist facility. (I.e. Major Trauma, Burns, Paeds, Decompression sickness, Confirmed STEMI, FAST positive CVA)

3.3.2. Crew requests that meet HEMS criteria warrant an immediate dispatch of the nearest aircraft (and doctor aircraft if necessary) within 3 minutes of request receipt.

3.3.3 Where requests do not meet HEMS criteria they are classified as Air Ambulance missions. In these cases HEMS flight exemptions do not apply. HEMS exemptions would be required to land in any public area e.g. built up areas, public parks, and sports fields.

3.3.4 Where there is uncertainty the duty aircrew can be contacted to assist in making this decision. Where there is limited information available this decision may be made in the air as more information becomes available from the dispatcher.

3.4 Specific conditions

3.4.1 Request for the conditions below must meet the criteria outlined:

- **Acute Myocardial Infarction** – Confirmed STEMI on 12 lead AND >20mins from PCI centre

- **Acute Stroke** – Confirmed FAST positive by paramedic or doctor AND meets thrombolysis criteria AND >20mins from Thrombolysis centre

- **Status Asthmaticus** – Acute severe asthma resistant to paramedic crew therapy AND >20 minutes from hospital. Any life-threatening asthma.

- **Status Epilepticus** – Seizures resistant to paramedic crew therapy AND >20 minutes from hospital

3.4.2 Any requests for other conditions should be considered taking into account:

- Whether HEMS exemptions apply and would permit landing at that site, or whether a secondary landing site would be required.
- Whether immediate land transfer would be quicker (usually if <20mins from hospital).

3.5 Air Ambulance Missions

3.5.1 Most other calls fall under the auspices of an Air Ambulance Mission. HEMS flight exemptions do not apply on these missions. Typical missions

included in this category are patient access problems, interhospital transfers (even if patient requires urgent medical assistance/transfer), non-urgent scene transfers (due to distance / land-asset non-availability). In these cases the air ambulance may only land at pre-surveyed landing sites (in residential / built up areas) or on non-public land e.g. farmland, countryside.

3.5.2 Where possible a doctor led aircraft should be kept available to cover the region for HEMS missions. Careful consideration should be given to requests for air ambulance missions where there is only one such aircraft on-line within the region.

3.5.3 It is recognised some missions need to be assessed on a case by case basis. Some Air Ambulance missions may require upgrade to HEMS missions. (For example: a paediatric emergency in a minor injuries unit). Where this is the case interpretation of the type of mission will be made by the attending aircraft crew and pilot.

4 LAND CREW DISPATCH REASONS

4.1 A land ambulance should be dispatched as per normal criteria regardless of whether an air ambulance is tasked or not. Reasoning for this includes:

- Safe movement of patient from incident/address to aircraft
- Potential for mechanical/weather/light restrictions
- Refusal of patient to fly
- Flight Safety
- Aggressive patients

4.2 Responding a Rapid Response Vehicle alone is not acceptable. In addition to the reasons stated above there are many instances which will require movement of a patient from home addresses to the aircraft, particularly those in urban areas.

5 SPECIAL CONSIDERATIONS

5.1 The nature of incident and any special considerations should not influence the initial dispatch of an aircraft. However, aircrew will be responsible for clinically assessing the safe and appropriate method of conveyance of patients.

5.2 Some of the following conditions which may influence aircrew decisions not to transport by air:

- Psychiatric/Suicide Attempts
- Pregnancy

- Convulsions
- Infectious Patients

5.3 Although the patients above may not be suitable for conveyance by Air Ambulance this does not necessarily mean the aircraft will not attend to offer support to Ambulance staff at scene in the event that a medic or additional Paramedic assistance be required.

5.4 In periods of increase demands to the land vehicle responses within the ambulance service, procedures may be relaxed to ensure medical personnel attend persons who require urgent medical assistance via the 999 system. Any clarification may be discussed with the Director of Specialist Operations and/or Air Operations/RTD MERIT Manager.

5.5 Consider travel and load time of Helimed when requesting their presence for rapid transportation to ensure patient's admission times are not prolonged

6 CANCELLATION OF THE AIRCRAFT FOLLOWING DISPATCH

6.1 The dispatch of the aircraft is based on either the reported type / severity of the incident and / or the patient(s) reported condition by the caller or through direct request from the health care provider on arrival at the scene. Cancellation of any of these responses must only be undertaken when further detailed assessment of injured patients, by a reliable source, confirms that these resources will definitely not make additional contribution to the management of the incident as a whole or to the clinical management of individual patients.

6.2 Prior to cancellation of the aircraft, clinical staff on scene should always be able to confirm that all patients have been adequately assessed and there are appropriate resources to deal with all patients on scene.

6.3 Clinicians on scene should also consider whether the air ambulance should continue to respond to an incident with the objective of providing advanced clinical skills more rapidly than by road transport to hospital.

6.4 Cancellation of the aircraft should only be considered when the following questions can be answered with a definitive "no":

6.4.1 Does the patient(s) require assessment or initial management above that of the current skills of the personnel on scene?

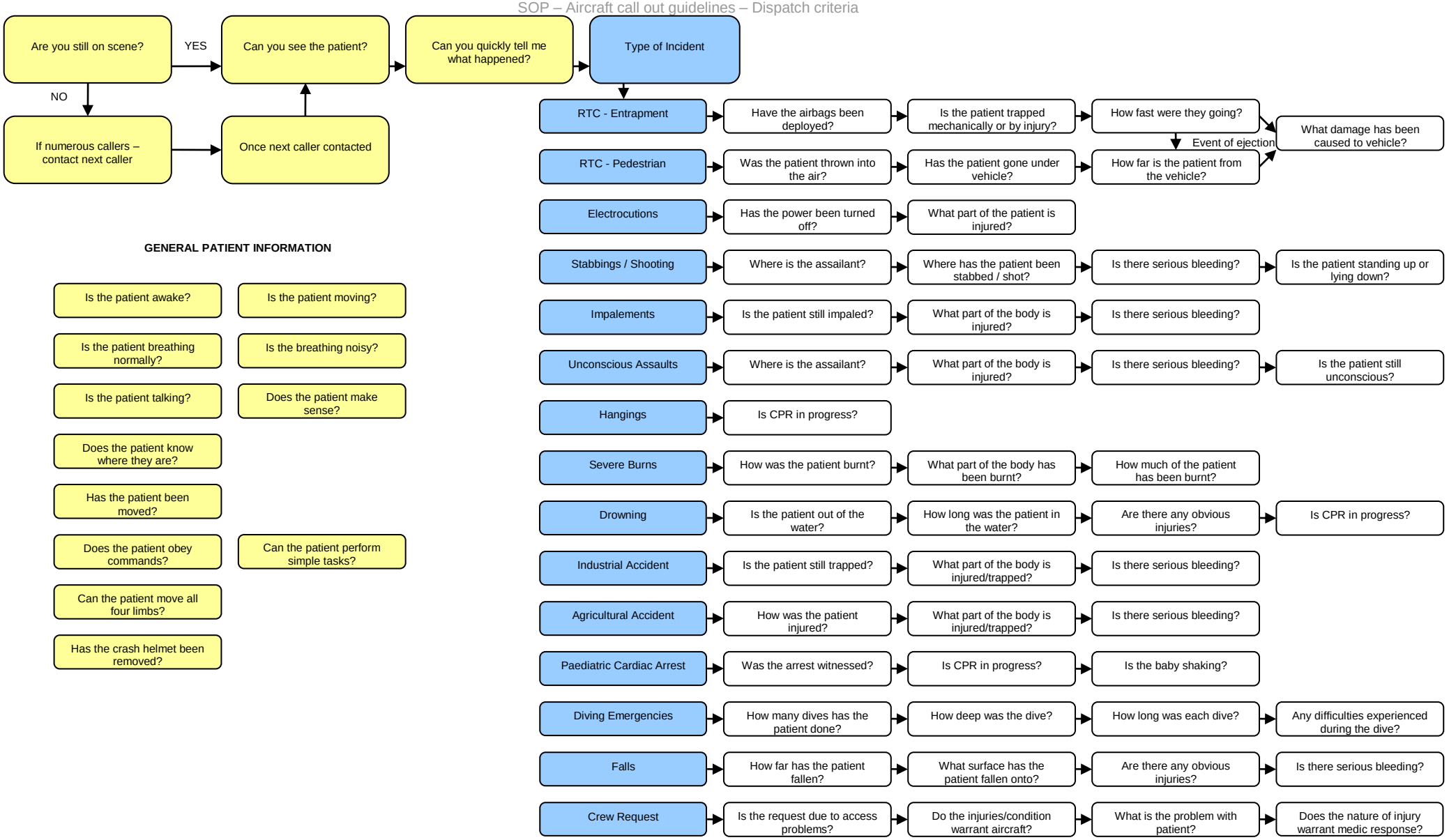
6.4.2 Would the conveyance to a specific specialised centre by air ambulance improve the outcome of the patients' condition (requirement for rapid surgery/ Major Trauma Centre / PCI)?

6.4.3 Is the patient still trapped?

6.4.4 Is the arrival of the air ambulance likely to be sooner than the arrival time at the most appropriate centre for care if transport is started now?

6.5 In cases of severe illness or injury, rendezvous at an agreed location with the ambulance should be considered as an alternative to stand down.

6.6. Clinicians on scene should be aware of, or request information on, the level of additional skills that can be offered by attending aircrew, when making clinical decisions



GENERAL PATIENT INFORMATION

- Is the patient awake?
- Is the patient moving?
- Is the patient breathing normally?
- Is the breathing noisy?
- Is the patient talking?
- Does the patient make sense?
- Does the patient know where they are?
- Has the patient been moved?
- Does the patient obey commands?
- Can the patient perform simple tasks?
- Can the patient move all four limbs?
- Has the crash helmet been removed?