Pre-Hospital Emergency Care Council

National Pre-alert Guidelines Standard

Mission Statement

"The Pre-Hospital Emergency Care Council protects the public by independently co-ordinating, developing, reviewing, regulating, and governing standards of excellence for the safe provision of quality pre-hospital emergency care."

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Version History

(**Please visit the** PHECC website **to confirm current version**.)

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Version	**Date**	**Details**
1	October 2019	Approved by Council
2	March 2024	Approved by Council

1. Purpose

This Standard of Operations provides guidance for all PHECC registered practitioners on what clinical presentations and situations a pre-alert to emergency department (ED) staff is required. It also informs ED staff of this guideline, which may assist with planning within the ED.

2. Background

The ED is a busy working environment providing care for patients with undifferentiated acute presentations. To provide appropriate care in a timely fashion, all patients attending ED are triaged initially into one of five priority levels. The highest priority 'Immediate', require clinical intervention immediately and are transferred into the resuscitation area. This triage process is extended to the pre-hospital emergency care environment when PHECC practitioners identify a clinical presentation that requires on-going immediate care on arrival at the ED. This process enables ED staff to prepare for an imminent arrival by allocating resources and staff for the emergency.

3. Benefits

All three stakeholders, (patients, PHECC practitioners and ED staff) benefit by having an allocated trolley available in the resuscitation area and the most appropriate senior clinical staff available to receive the 'Immediate' patient.

4. General

The National Standards for Safer Better Healthcare, HIQA, 2012, has specified 'Continuity of care and support is important for each service user to ensure that no one, and no part of their treatment, falls through gaps in the provision of services' as a process for safe healthcare. By pre-alerting ED staff of an imminent arrival of a patient that requires on-going immediate care, PHECC practitioners will enable the continuity of acute care to be maintained.

5. Process

When a clinical presentation that requires immediate on-going care on arrival at an ED, the receiving ED staff should be pre-alerted in a timely manner by the PHECC practitioner. The clinical presentations identified as requiring pre-alert are outlined in this document, however should a PHECC practitioner have a concern that their patient may require on-going immediate care on arrival at ED, and the presentation is not listed herein, they should pre-alert the ED staff.

The following presentations should normally trigger a pre-alert and ASHICE message to the receiving ED.

Clinical Assessment

A Airway compromise or difficulty maintaining airway patency

B Respiratory rate < 10 or > 29, (see ICTS table below for Paediatric values)

Oxygen saturations < 90%, not responding to treatment

C Pulse < 50 or > 120, (see ICTS table below for Paediatric values)

SBP < 90 or > 220 mmHg, (see ICTS table below for Paediatric values)

Uncontrolled/massive haemorrhage

D GCS ≤ 8 or, P or U on AVPU (non-trauma)

GCS ≤ 13, V, P or U on AVPU (trauma)

Paralysis

Situational

Multiple patients expected (> 3)

Isolation precautions required

Clinical Concern – at practitioner's discretion

Specific Clinical Conditions

Include but not limited to:

- Cardiac Arrest and/or Post ROSC
- FAST positive patients or stroke suspected
- STEMI or Non-STEMI suspected
- Specific Injuries:
  - Airway injury, hoarseness or stridor
  - Respiratory compromise
  - Suspected respiratory tract burns
  - Cyanosis, crepitus or subcutaneous emphysema
  - Multiple rib fractures
  - Severe pain or evidence of seatbelt abrasion, contusions or blunt impact to chest
  - Significant chest wall trauma
  - Severe haemorrhage
  - Arterial bleeding
  - Penetrating injury (except isolated superficial limb injuries)
  - Amputations
  - Signs of skull fracture
  - Following head injury, > 2 vomiting episodes or seizures
  - Spinal cord injury with neurology
  - Abdominal pain, rigidity, distension or swelling
  - Pelvic fracture
  - ≥ 2 long bone fractures
  - Limb-threatening injury
  - Burns > 10% BSA

- Meningitis suspected
- Sepsis
- Uncontrolled seizures
- Dangerous patient: risk to self or others
- Pregnant patient: imminent delivery, prolapsed cord
- Suspected diabetic ketoacidosis (DKA)
- Life-threatening asthma
- Stridor
- Toxidromes
- Acute confused states
- Severe uncontrolled pain
- Neck of femur fracture (where local pathways are in place)
- Protocol 37 where the destination is the ED

Mechanism of Injury

- RTC: > 60 km/hr, roll over, relevant passenger compartment intrusion > 30 cm, body ejection (partial or complete), death on scene
- Prolonged extrication > 20 minutes
- Motor cyclist, Cyclist, Pedestrian Collision: patient thrown/run over with significant impact
- Fall > 2m or 10 steps ***or*** 2 x patient's own height ***or*** fall off ladder > 1m
- Industrial/blast injury
- Large animal injury such as collision, fall or trampled
- Bullseye in windscreen caused by patient contact
- Penetrating trauma to head, neck, torso and proximal limbs
- Submersion, diving, suspension or electrical injury

Paediatric Abnormal Vital Signs reference grid *Ref: Irish Children Triage System (ICTS)*												
Age	**0 -3 months**		**4 – 6 months**		**7- 12 months**		**1 – 3 years**		**4– 6 years**		**> 7 years**	
	low	high	low	high	low	high	low	high	low	high	low	high
RR	30	61	30	61	25	46	20	31	16	25	13	21
HR	89	180	89	180	79	140	74	130	69	110	59	90
Systolic Blood Pressure												
Neonate (< 7 days)		**Neonate 8– 30 days**		**Infant < 2 years**		**Children 2 – 5 years**		**Children 6 -9 years**		**Children 10 – 12 years**		**Adolescent 13 – 15 years**
low	high	low	high	low	high	low	high	low	high	low	high	low	high
<70	≥96	<70	≥104	<75	≥112	<80	≥116	<90	≥122	<90	≥126	<100	≥136
SpO_2: < 90% for all												

Supported by the National Clinical Programme in Emergency Medicine

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