Over the last few years and as per the following UKRO Website Article, the Extrication Review Group (ERG) have been updating a variety of UKRO documentation. As part of this process existing Medical Assessors and Medical Subject Matter Experts (SME), from varying backgrounds, have been reviewing the Medical Scoresheets/Guidelines, in order to keep the Extrication Challenge up-to-date and current in the world of pre-hospital care, while demonstrating that we are promoting practice at the cutting edge of clinical care.

One unanimous agreement was the need for Extrication Team medics to verbalise what they are doing and why, with the emphasis upon a hands-on approach. This ensures that the attention of the Medical Assessor(s) is drawn to the fact that clinical assessment and care is being delivered, inclusive of actions which may not be able to be physically observed by a Medical Assessor(s) due to the nature of the Scenario. Verbalising ‘I am now going to take your pulse’ when one isn’t being taken will be reflected as no pulse check having been completed within the assessment (Refer also to Sub-Section 4.8 of the Extrication Challenge Programme). An Extrication Team medic must demonstrate their skills, knowledge and understanding to gain maximum marks.

The use of relevant medical terminology is encouraged though inappropriate use of such medical terminology will not be positively marked and if felt to be incorrectly used may result in marks not being awarded. It’s important to remember that Medical Assessors are looking for competent firefighters in the role of the team medic and high marks can be achieved with a competent systematic assessment of the basics.

The ‘Standard’ Scenarios will only consist of casualties whose injuries will be conducive with a controlled extrication within the Scenario 20 minute timeframe.

It is expected that information relating to an Interior Assessors/Casualty(s) injuries must be elicited by questioning the Interior Assessors/Casualty(s), as would be the case at an operational incident. Medical Assessors will give no additional information or prompts to aid the assessment of injuries.

In line with the consensus statements published by the Faculty of Pre-Hospital Care over the last year, the ERG has updated the Medical Scoresheets/Guidelines accordingly. The relevant published consensus statements relate to pre-hospital spinal immobilisation and pelvic splintage.

Spinal injuries are relatively uncommon. It is reported that between 0.5%-3% of patients presenting with blunt trauma suffer spinal cord injury, with approximately 50% of these injuries caused by land transport in the United Kingdom (UK). Immobilisation is based on the logical premise that preventing movement should decrease the incidence of spinal cord injury or further deterioration of existing damage. Immobilisation is widely used in the pre-
hospital setting regardless of whether mechanism of injury or clinical findings would support its use. Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance suggests all patients should be initially immobilised if the mechanism of injury is suggestive of spinal cord injury. The guidance gives a list of criteria which, if absent, allow removal of immobilisation\(^3\).

The consensus outcomes relevant to the UKRO medical assessment are as listed below:

- The long spinal board is an extrication device solely. Scoop stretchers will not be available during this year’s National Challenge.
- Manual in-line stabilisation is a suitable alternative to a cervical collar.
- An immobilisation algorithm may be adopted by the Faculty of Pre-Hospital Care. As yet this has not been finalised, and it will become part of the assessment process once available.
- There may be potential to vary the immobilisation algorithm based on the conscious level of the patient.

The consensus group recognise that a change is needed from a policy of immobilising necks as much for the protection of the clinician as for that of the patient, to a system of selective immobilisation designed to reduce the risks to the trauma victim. Practitioners should be made aware that cervical collars are not the panacea that they are often made out to be and that manual in-line stabilisation is often a more beneficial and acceptable modality compared with triple immobilisation\(^1\).

It’s important to remember the objective of the UKRO event is to develop extrication techniques and patient care. It is for this reason all scenarios this Challenge Year will consist of casualties whose injuries will require spinal immobilisation. Marks are awarded for good assessment and appropriate management.

Pelvic injuries remain a significant cause of morbidity and mortality within the UK even with advances in hospital care. Massive haemorrhage associated with unstable pelvic fractures continues to be one of the leading causes of death. Pelvic binding devices now allow early stabilisation in the pre-hospital environment.

Whilst it is not expected that Extrication Teams will use pelvic binders, the consensus outcomes relevant to the UKRO medical assessment process are listed below:

- A pelvic binder is a treatment intervention and should be applied early.
- Adequate training must be provided to avoid misplacement of devices.
- Associated femoral fractures should also be reduced.
- Patients should not be log rolled or transported on a spinal board.
- Use of pelvic binders is associated with the risk of low pressure skin necrosis (i.e. breakdown of the skin).
The pelvic binder should be placed next to skin (From a UKRO perspective, where utilised, it is appropriate to place such a device over the Interior Assessor(s)/Casualty(s) protective overalls).

A pelvic binder should be applied prior to extrication\(^{(2)}\).

For this Challenge Year the use of a pelvic binder is not a requirement during Scenarios. Extrication Team medics who have received appropriate advanced training and who choose to utilise a pelvic binder may do so based on their clinical assessment.

It is recognised that pre-hospital care is an ever-changing field. As such, Medical Assessors appreciate variances within practice. It’s felt that whilst more changes could have been introduced, the updates introduced this Challenge Year are appropriate to ensure improvements but appreciate the spread of practice and experience from across all Fire and Rescue Services (FRS). The importance of all competitors operating within their own level of competence is not only required at operational incidents, but essential to ensure marks are not lost by overlooking the need to manage the basics.

A continual development process is planned to follow this Challenge Year’s review to continually strive to develop the most up-to-date practices in line with the role of a firefighter.

References: