



Aeromedical Evacuation-Patient Movement Patient Safety Program Guide



Current as of 29 January 2014

Air Force Patient Safety

Mission:

Above all else, we are committed to patient safety and the elimination of preventable medical errors. In recognition of this commitment we strive to deliver quality care and sustain a culture of patient safety in all our healthcare delivery settings to include aeromedical evacuation, expeditionary medical support and deployed locations.

Vision:

Leading the way toward a culture of patient safety through proactive leadership

Aeromedical Evacuation

Mission:

Plan, organize, train and equip AE forces to provide time-sensitive en route care of regulated casualties to and between medical treatment facilities, using organic and/or contracted aircraft. AE Patient Safety functions to improve overall patient safety by problem assessment, solution recommendations, implementation and dissemination of patient safety information within the AE system.

Vision:

Unrivaled En Route Care... Responsive, Agile, Global!

Why Patient Safety?

Patient Safety promotes the USAF SG goal of providing quality, world class healthcare anywhere in the world at any time. A robust Patient Safety Program drives the examination of systems and processes to correct failures before they result in harm to a patient. Patient safety proactively and retroactively identifies potential and actual risks to safety and uses elements of human factors and systems sciences to identify underlying causes and makes the necessary improvements to reduce risks to patients.

Contact: AMC/SGK at AMC_AE_Pt_Safety@us.af.mil for suggestions for additions, updates or improvements. AMC/SGK is the POC for all corrections, additions and changes to this document.

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SECTION I – AE/ERC PATIENT SAFETY PROGRAM (PSP) OVERVIEW

INTRODUCTION TO PATIENT SAFETY IN THE AE/ERC ENVIRONMENT:

The aeromedical evacuation (AE) and patient care in the en route care (ERC) environment presents unique challenge. Physiological effects of altitude, limited access to a medical provider and ancillary resources, frequent patient handoffs, and mandated use of specialized medical equipment are important factors to be considered during the patient regulation and movement process. Understanding these challenges, detailing accurate medical information and reporting safety events help mitigate safety events and improve the AE environment.

Having access to accurate and detailed patient documentation as they transverse the AE system is vital to the AE patient safety program. Frequently a patient's final destination is several continents away before an event is reported. In cases like these, locating facts, statements and records to review an event can be challenging. Health care providers must provide detailed patient documentation and ensure this information is stored in the patient's medical record. Additionally, timely reporting of patient safety events help leadership track trend(s) and root cause(s), which ultimately lead to improvements in patient care.

The AE environment is unique for providing quality patient care when compared to the typical clinical setting. The physiological effects of altitude on the body, limited and/or lack of many immediate ancillary resources (x-ray, lab) and the need for additional air-worthy equipment, are all important factors that must be carefully weighed and considered for each patient's safety when validating and preparing them to be placed into the AE system.

The aircraft environment alone provides many conditions for safety consideration to include such hazards as tripping/ fall hazards, pressurization concerns, and environmental/ thermal concerns. Also, patient oxygen requirements may be different at altitude versus on the ground. Learning about the AE environment will induce better plans for a more effective and safe patient movement.

Another aspect of patient safety in AE that may differ from the ground clinical setting involves the perpetual movement of the AE patient population over space and time throughout the enroute care continuum. Due to this factor, reporting accurate, detailed information in a timely manner is vital to resolving issues in the AE environment. In cases when there is a delay in reporting, due to mission completion/requirements, getting facts and statements and records to review a significant event can become more challenging.

Patient Safety Objectives in Patient Movement and AE (AFI 41-307, Attachment 14)

These include but are not limited to:

- Ensure an acceptable standard of patient safety at all levels
- Provide an ongoing and systematic approach for assuring the quality of patient care
- Reduce events that cause potential or actual patient harm through risk identification
- Identify mechanisms to assess and monitor system-wide problems
- *Improve patient satisfaction within the AE system*
- Provide up-to-date Patient Safety/Clinical Performance Improvement information to all AE personnel

CULTURE OF SAFETY (AFI 44-119, Ch. 2)

A culture of patient safety is demonstrated by an organizational commitment to provide safe, high quality patient care via a focus on collaborative teamwork, communication and effective processes. This commitment must be shared by leadership and staff members at all levels. All personnel involved in the AE process, whether on the ground or in the air, share an important role and responsibility in executing this commitment to identify and reduce risk before it happens.

KEY CONCEPTS OF A “JUST CULTURE” (Ref: Handbook of Patient Safety Managers. pg 36)

In a “Just Culture,” a methodology developed by David Marx, JD., people are not blamed for errors and mistakes, as they are often caused by factors external to the worker. However, there is a system of accountability for willful acts of recklessness and disregard of safety practices.

- Acknowledges that most healthcare workers are not reckless and should not be ‘blamed’
- Promotes trust and encourages event reporting and identification of near miss/close calls as well as actual events. No one is ‘punished’ for reporting
- Promotes a “lessons learned” approach, where staff members are comfortable sharing.

SECOND VICTIM

The term “second victim” in healthcare is now being used to recognize that healthcare professionals can be impacted and even traumatized by an unintended medical error or event. While this is certainly not a new concept, support for the second victim has not always been provided. When this occurs, healthcare professionals are often left to suffer in silence. Below are some common signs and symptoms shared by second victims, suggested actions for peers and supervisors in providing support, and the typical recovery path. Leadership, providers, and healthcare personnel are all encouraged to do more reading and understanding of the second victim in healthcare to better support each other. Commanders should have a plan on how their unit or squadron will respond to support second victims.

Physical Symptoms:

Sleep disturbances
Difficulty concentrating
Eating disturbances
Headache
Fatigue
Nausea/vomiting
Diarrhea
Rapid heart rate
Rapid breathing
Muscle tension

Psychological Symptoms:

Isolation
Frustration
Fear
Uncomfortable returning to work
Anger and irritability
Depression
Extreme sadness
Self-doubt
Flashbacks
Feeling numb

Dr Charles Denham of the Texas Medical Institute of Technology (TMIT) proposes the following 5 rights for second victims using the acronym **TRUST**:

- **T**reatment that is just
- **R**espect
- **U**nderstanding and compassion
- **S**upportive care
- **T**ransparency and opportunity to contribute

- Supportive actions:
 - Reach out to the second victim and be present
 - Actively listen without judgment or criticism
 - Let them know you still have confidence in them
 - Stay in touch over time, keeping checking in with them
 - Be especially supportive as they go through any investigation or review process
 - Recommend support services if needed

| Stage 1 - 3 | | | Stage 4 | Stage 5 | Stage 6 | | |
|--|-----------------------|------------------------------|--------------------------|-------------------------------|--------------|---|----------|
| Impact Realization | | | Enduring the Inquisition | Obtaining Emotional First Aid | Moving On | | |
| Chaos & Accident Response | Intrusive Reflections | Restoring Personal Integrity | | | Dropping Out | Surviving | Thriving |
| (Individual may experience one or more of these stages simultaneously) | | | | | | (Individual migrates toward one of three paths) | |

**** Provided here with permission by University of Missouri Health System**

NATIONAL PATIENT SAFETY GOALS APPLIED TO PATIENT MOVEMENT:

GOAL 1. Improve the accuracy of patient identification

- Use two patient identifiers; full name and date of birth
- Eliminate transfusion errors related to patient misidentification



It is imperative for all en route care patients to wear an identification band generated from USTRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES). This ID band will match demographics listed on AE documentation. The ID band has patient's cite number on it and will be checked on each mission by the flight nurses when they assess the patient and provide any type of patient care.

GOAL 2. Improve the effectiveness of communication among caregivers

- Report critical results of tests and diagnostic procedures on a timely basis



Communication is important in all aspects of patient movement. Not only must critical results be reported but all status changes must be addressed at every hand-off and at every point in the system to ensure the patient is still safe to fly or to provide updated information for their plan of care to the Validating Flight Surgeon (VFS), Clearing Flight Surgeon (CFS) or next caregivers.

GOAL 3. Improve the safety of using medication

- Label medications & solutions
- Reduce harm from anticoagulant therapy
- Maintain and communicate accurate patient medication information



Performing an accurate Medication Reconciliation at each transition point in the patient movement system is a valuable tool to avoid many patient preparation errors.

GOAL 7. Prevent and reduce the risk of healthcare-associated infections

- Follow Hand Hygiene guidelines; CDC or WHO
- Prevent central line, surgical site, catheter associated UTI, and other infections due to multidrug-resistant organisms in acute care hospitals

GOAL 9. Reduce the risk of patient harm resulting from falls

- The organization implements a fall reduction program that includes an evaluation of the effectiveness of the program.



The area in and around the aircraft may present tripping hazards and/or fall risks to all personnel and patients operating around the AE mission. Increased awareness of these hazards and a good assessment of patients more susceptible to/identified as "fall risk" help mitigate these safety issues

GOAL 14. Prevent health care-associated pressure ulcers (decubitus ulcers)

- Assess & periodically reassess each patient's risk for developing a pressure ulcer & take action to address any identified risks.



As patients move throughout the patient movement system it is critical that aircrews and ground medical personnel assess and reassess the points of contacts between the

patient and the surface they are positioned on. As a patient travels through the system their skin integrity can be increasingly affected by the cumulative stress on the points of weighted contact to a litter mattress or blanket.

GOAL 15. Identify safety risks inherent in its patient population.

- Identify patients at risk for suicide.



It is imperative healthcare professional's document subjective and objective assessments, which may indicate need for mental health consultation; even if the patient is not classified as a mental health patient.

ERC PATIENT SAFETY GOALS

En route care (ERC) Patient Safety Goals were developed from PMQ-R data trends that were high risk, problem prone or high volume. It is recommended that every AE Squadron, Staging Facility and Sending/Receiving medical Treatment Facility involved in patient movement review applicable goals and determine how well they are meeting these goals.

ERC GOAL 1 Improve Patient Preparation & Handoff Communication throughout the Aeromedical Evacuation (AE) System.

- SUB-GOAL 1.1 Utilize I-SBAR Handoff Checklists to augment handoffs within the AE system

ERC GOAL 2 Sending MTF/Staging Facility reviews & develops internal Medication Management & Reconciliation processes for all AE patients

ERC GOAL 3 Improve Safe and Effective Pain Management across the continuum (Epidural, PCA, & PNB)

- SUB-GOAL 3.1 Use of recommended standardized concentrations for narcotics with PCA for AE patient movement
- SUB-GOAL 3.2 Use & documentation of a sedation scale and pain scale as part of ongoing assessments
- SUB-GOAL 3.3 Obtain & sustain competency and proficiency with use of PCA

ERC GOAL 4 Ensure Adequate Supply of O2 for transport (O2 tanks and NPTLOX)

- SUB-GOAL 4.1 Sending facility calculate O2 needs to support roundtrip ground transport plus additional residual amount per local policy
- SUB-GOAL 4.2 Ensure PTLOX, NPTLOX, or mission O2 source is properly maintained and mission ready

ERC GOAL 5 Improve Communication

- SUB-GOAL 5.1 Utilize CRM/TeamSTEPPS communication tools to promote teamwork and communication
- SUB-GOAL 5.2 MCD will notify C2 for patient status changes

ERC GOAL 6 Improve clinical documentation

- SUB-GOAL 6.1 Ensure accurately transcribed and complete Medication Administration Record (MAR) AF IMT 3899I
- SUB-GOAL 6.2 Ensure complete documentation of patient assessments in the AF IMT 3899 series

SECTION II – PATIENT SAFETY PROGRAM FOR THE PS MANAGER (PSM)

REPORTING PATIENT SAFETY EVENTS IN THE AE SYSTEM

(AFI 41-307, Attachment 14; Aeromedical Evacuation Forms Guide pg 21-28)

AE Event (previously termed incident)

- An occurrence or condition associated with a potentially preventable medical event that may or may not result in harm.
- Actual AE events may be due to acts of commission or omission

Near Miss

- Any process variation or error that could have resulted in harm to a patient or aircrew member, but through chance or timely intervention did not reach the individual
- Such events are also referred to as “close calls”

CLASSIFICATION OF EVENTS:

AE Event Classifications: Occurrences or conditions associated with care or services provided within the AE system which reach the patient and may or may not have caused unexpected harm to a patient (but may be a crew member/CCATT/medical attendant or passenger) during care or services.

- Capture not only events causing harm but also near misses with a high potential for causing harm
- Are based on the degree of harm or disability to the patient involved
- Are comparable to the Safety Assessment Code (SAC)

| Event Classification | Description |
|----------------------|---|
| A | Event involving immediate death, near death or major permanent loss of function. Immediate notification to TACC/AMD/AECT/TPMRC. Submit DD Form 2852 into TRAC2ES PMQ-R database within 24 hours. |
| B | Serious temporary patient harm or status change resulting in initial or prolonged hospitalization. |
| C | Event involving temporary patient harm or status change requiring emergency evaluation and treatment. |
| D | Event did not result in patient harm but increased monitoring is required. |
| E | Event reached the patient but did not result in patient harm or need for increased monitoring. |
| F | Event did not reach patient and did not result in patient harm but is a potential system issue, hazardous condition or has the potential to cause harm. |

A / B / C classified events

- May elicit and/or requires quick responsive review and assessment by lead Command
- A Event must be **entered** into TRAC2ES **within 24 hrs** to enable proper notification

D / E / F Classified events

- Entered within a reasonable amount of time.

AE EVENT REPORTING

HOW DO EVENTS GET REPORTED?

The AE system uses the DD Form 2852, Patient Movement Event/Near Miss Report:

NOTE: See attachment 1, the most current version is Feb 2011, other previous formats are obsolete

Purpose: Overall purpose is to capture AE system process trends

Who completes the form?

Any person to include aeromedical evacuation crew member (AECM), aeromedical staging facility (ASF), critical care aeromedical transport team (CCATT), aeromedical staging squadron (ASTS) or military treatment facility (MTF) personnel who witnesses an event

NOTE: If completed by ASF or MTF staff, follow local MDG incident reporting policy **in addition to** completing this form. When the DD Form 2852 is complete, give it to individual with TRAC2ES PMQ-R permission/access and/or the PSM for entry into TRAC2ES. The TRAC2ES (USTRANSCOM web-based system) is located at <https://www.trac2es.ustranscom.mil>

TIPS FOR MORE EFFECTIVE REPORTING:

As the 2852 Author:

- Fill out the form to COMPLETELY
- Identify an event, near miss
- Provide a detailed description of the event; INCLUDE all pertinent information in the EVENT DESCRIPTION box (equipment S/N; event, and results from crew responses to event)
- Provide the best information while it is fresh in your memory
- DD Form 2852s are read/reviewed at several levels from the squadron, to the wing, MAJCOM and COCOM

Complete the form with a complete description including the following:

- Objective data –
 - provide facts and observations
 - Medication name, directions, and dosages
 - Equipment serial numbers
- Subjective data
- Any actions taken to resolve event
- Outcome / resolution

Anyone who completes a DD Form 2852 needs to check their work and the unit PSM needs to review it and ask the following to verify completeness:

- Who? - Who was involved? Who took actions? Who did you notify?
What? - What happened? What actions were taken? Include Vital signs taken.
When? - What date and time did this occur?
Why? - Why did this happen? What contributed to the event?
Where? - Where did the event occur? In –flight? What leg? On the ground in the ambus?

Example of common 2852 that falls short of good reporting:

Pt O₂ sat 88%. Placed on O₂ at 2 LPM by NC. Pt tolerated rest of flight.

- What were the vital signs before and after?
- Was the pt on any medication that could have contributed to this event or was it the effects of altitude?
 - Many crews will respond: “it’s on the PMR” –Some meds are indicated on the PMR, but actual administration is not. PMRs are a snapshot in time, the actual medications the pt may have taken may be different
- When did you find this sat? Pre-flight? At cruise?

Example of better description of same event:

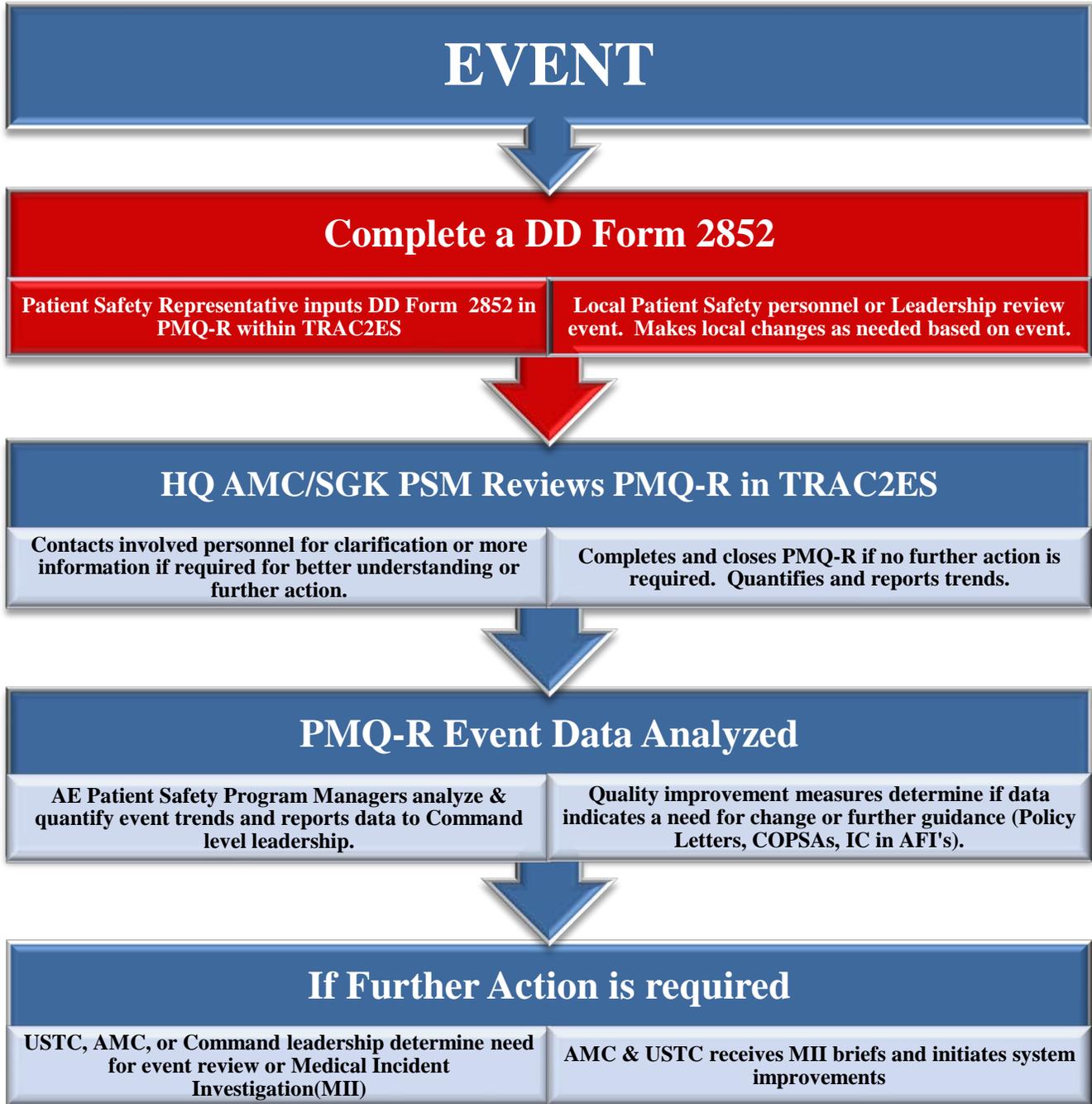
Priority pt, dx: tib/fib fx: Pt was reported to have been pre-medicated with 4 mg IVP Morphine by the CASF 30 mins before flight. Initial Pre flight O₂ sat 98%, BP 114/53, HR 67 RR 14. Enplaned without difficulty. At cruise, vital sign recheck pt O₂ sat 88%, BP 110/45, HR 62 RR: 16. Applied O₂ via nasal cannula at 2 LPM IAW AFI 41-307. Pt O₂ sat increased to 98%. Pt tolerated rest of flight without difficulty. O₂ sat remained 98% by hand off. (Cabin altitude 7000ft)

NOTE: The personnel reviewing and analyzing the PMQ-R at all levels at not present for the event; making it imperative to fully describe events and support objective information.



DD FORM 2852: FLOW PROCESS

- Patient Safety Managers (PSM) from AMC and other COCOMs/MAJCOMs review **all** PMQ-Rs for quality assurance, trends, and follow-up on events require more in-depth review
- Trends or individual events may indicate a need for process improvement, policy change or identify a need for critical assessment in the form of a Root Cause Analysis (RCA), Event Review or Medical Incident Investigation (MII)



AE PATIENT SAFETY EVENT REVIEW PROCESSES:

Note: All Patient Safety focused event reviews are protected from disclosure under Section 1102 of U.S.C. 10

Event Reviews and Investigations

- All events linked to causing patient harm (class A, B, and significant C Events) will be evaluated to determine if a deeper review or investigation is required
- The AE system uses two types of deeper review processes: Event Review and Medical Incident Investigation
- Although reviews are typically done on harm events, they can be done on any class of event as determined by leadership
- AE involves multiple patient handoffs across a continuum of care; most reviews will involve multiple units and may cross Theaters, Commands and Services. Because of this, USTRANSCOM/SG office directs the review process in coordination with other Commands

Event Review (also known as Root Cause Analysis)

- An internal review process utilizing selected personnel not directly involved in the event to work on a review team
- In the AE system, a team may be made up of 1-2 personnel from multiple units involved in a patient move
- The team will develop a timeline of events and identify root causes along with recommendations for system improvement

Medical Incident Investigation (MII)

- An MII is a formal investigation made up of an external medical team
- This team may travel to multiple units to conduct interviews and devise a timeline of events
- Root causes along with recommendations for system improvement are presented in a formal briefing to AMC/SG and USTRANSCOM/SG

PROGRAMS TO HELP PREVENT, IDENTIFY, AND MITIGATE SAFETY EVENTS

Note: TeamSTEPPS® was based off of the Crew Resource Management Concepts. Both systems provide great tools to utilize within the patient movement system. They are focused on good core teamwork and communication.

CREW RESOURCE MANAGEMENT (CRM) (Ref: AFI 11-290, Section A)

AE crews are required to follow the guiding principles of CRM at all times on their mission

Situational Awareness

- Includes knowledge and skill objectives for preventing the loss of situational awareness, skills for recognizing the loss of situational awareness, and techniques for recovering from the loss of situational awareness

Crew Coordination/Flight Integrity (Leadership and Assertiveness)

- Knowledge and skill objectives covering the impact on aircrew performance of command authority, leadership, responsibility, assertiveness, conflict resolution, hazardous attitudes, behavioral styles, legitimate avenues of dissent, and team-building

Communication

- Includes knowledge of common errors, cultural influences, and barriers (rank, age, experience and position)
- Skills will encompass listening, feedback, precision and efficiency of communication with all members and agencies

Risk Management/Decision Making

- Includes risk assessment, the risk management process, tools, breakdowns in judgment and *flight* discipline, problem-solving, evaluation of hazards, and control measures

Task Management (Adaptability/Flexibility)

- Includes establishing priorities, overload, underload, complacency, management of automation, available resources, checklist discipline, and standard operating procedures

Mission Planning/Debrief (Mission Analysis)

- Includes pre-mission analysis and planning, briefing, ongoing mission evaluation, and post mission debrief
- Also includes, specific tools and techniques to be used in operational and training missions

TEAMSTEPPS® (TEAM STRATEGIES AND TOOLS TO ENHANCE PERFORMANCE AND PATIENT SAFETY)

Ref: DOD Patient Safety, <http://health.mil/dodpatientsafety/ProductsandServices/TeamSTEPPS.aspx>

GOAL: To produce highly effective medical teams that optimizes the use of information, people, and resources to achieve the best clinical outcomes for our patients

- Based off the concepts of **Crew Resource Management**, which Flight and Aeromedical Evacuation crews have been utilizing for quite some time
- The 5 key principles of **TeamSTEPPS®** are:
 - Team structure, Leadership, Situation Monitoring, Mutual Support, Communication
- Effective teamwork and communication are essential for positive outcomes in all healthcare settings

TeamSTEPPS® TOOLS (limited selection of tools can be used in conjunction with CRM. For more tools and resources please refer to <http://www.ahrq.gov/teamstepstools/>):

Two Challenge Rule:

- Team members are responsible for speaking up at least two times when concerned for a patient's safety
 - The challenged team member must acknowledge
 - If the outcome isn't satisfactory, take a stronger course of action or utilize the supervisor or chain of command

SBAR: (see I-SBAR designed for Hand-off use Attachment 1)

- A technique for communicating information that needs prompt attention
 - Situation = what is going on with the patient?
 - Background = what is the clinical background?
 - Assessment = what do you think the problem is?
 - Recommendation = what do you want to be done?

Call-out:

- A technique used to communicate important information to the team simultaneously
- When directing an action, ensure a specific individual is directed to complete the task
- When completed, that person can call out ("IV is in") to inform the team and help with

anticipation of next steps

Check-Back:

- A closed loop communication technique to ensure that the message was understood correctly.
 - The sender initiates ('Start a Normal Saline IV at 200cc/hr')
 - The receiver provides feedback ("Normal Saline IV at 200cc/hr)
 - The sender double checks to ensure the message was received ("That's correct')

SECTION III – COMMUNICATION OF PERTINENT INFORMATION

SYSTEM ALERTS & ADVISORIES

USAF SG NOTAMs: Notices to Airman (NOTAMS) that are published to notify the Air Force healthcare community of an identified risk to safe care.

- They include a description of the event or problem and recommendations for prevention
- NOTAMs can be accessed through the following hyperlink:
- <https://kx2.afms.mil/kj/kx1/Quality/Pages/cqm-policies-notams-front-page-16-may-13.aspx>

NOTICE TO AIRMEN

Individuals should review NOTAMs as they are published

- Consider applicability to your mission and patient population.
- Look for NOTAMs within your facility.

COPSAs: HQ AMC Clinical Operations and Patient Safety Alerts (COPSA)

- COPSAs are used by HQ AMC to communicate patient safety information to the global AE Community.
- Accessed on the SharePoint at: [Clinical Operations and Patient Safety Alerts](https://eis.af.mil/cs/usafae/sg/SG%20Documents/Forms/AllItems.aspx)
<https://eis.af.mil/cs/usafae/sg/SG%20Documents/Forms/AllItems.aspx>

Alerts and Advisories: published by national and military sources on identified risks involving any aspect of health care.

- Review for applicability and implement as indicated.
- Alerts are available at <http://www.health.mil/dodpatientsafety/Alerts.aspx>

AE CREW ALERTS & ADVISORIES OVERVIEW(AFI 11-202, V 2)

Flight Crew Information File (FCIF): A collection of publications and material determined by the MAJCOM and unit as necessary for day-to-day operations.

Special Interest Items (SIIs): Are items of emphasis relating to existing procedure(s) designed to mitigate or eliminate specific risks or trends.

Flight Crew Bulletins (FCB): May include local procedures and policies, concerning equipment and personnel generally not found in any other publications.

SECTION IV – PATIENT PREPARATION FOR SENDING FACILITIES

MEDICATION RECONCILIATION: APPLYING PRINCIPLES TO THE AE SYSTEM

The AE system provides a complex environment for medication administration. AE personnel carry a limited supply of medications. Therefore, getting the orders and medication supply right at every transition point throughout the AE system is vital to maintaining continuity of care.

Goals:

- To avoid complications related to incorrect or conflicting orders or, incorrect medication supplies (wrong dose, wrong med, insufficient supply).
- To avoid medication errors that result from those complications listed above
- To provide the best quality care and continuity of care for all of our patients

******“ 3 RELIABLE STEPS”****** An easy tool to use to perform a good medication reconciliation

Verification:

- Obtain a complete and accurate list of current medications: name, dose, frequency and route
 Obtain 3899 and verify the doctor’s orders and patient informatio.

Validation:

- Review current medications and indicate which are to be continued, discontinued or changed
 Validate 3899I and MAR.

Clarification:

- Compare medication list with medication orders and medications on hand for or with patient at each transition of care
 Compare the: doctor’s order; 3899; 3899I; MAR with the medication on hand or delivered with the patient. In addition, confirm the medication is labeled correctly.

*****References:**

Barnsteiner, Jane H., *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, Hughes RG, editor. Chapter 38, Rockville (MD): *Agency for Healthcare Research and Quality (US)*; 2008 Apr: On line:
<http://www.ncbi.nlm.nih.gov/books/NBK2648/>

Institute for Healthcare Improvement Medication reconciliation at all transitions Tool

*<http://app.ihl.org/imap/tool/#Process=7ce51016-b4f0-423c-9f8b-5e1ea8d7b810>

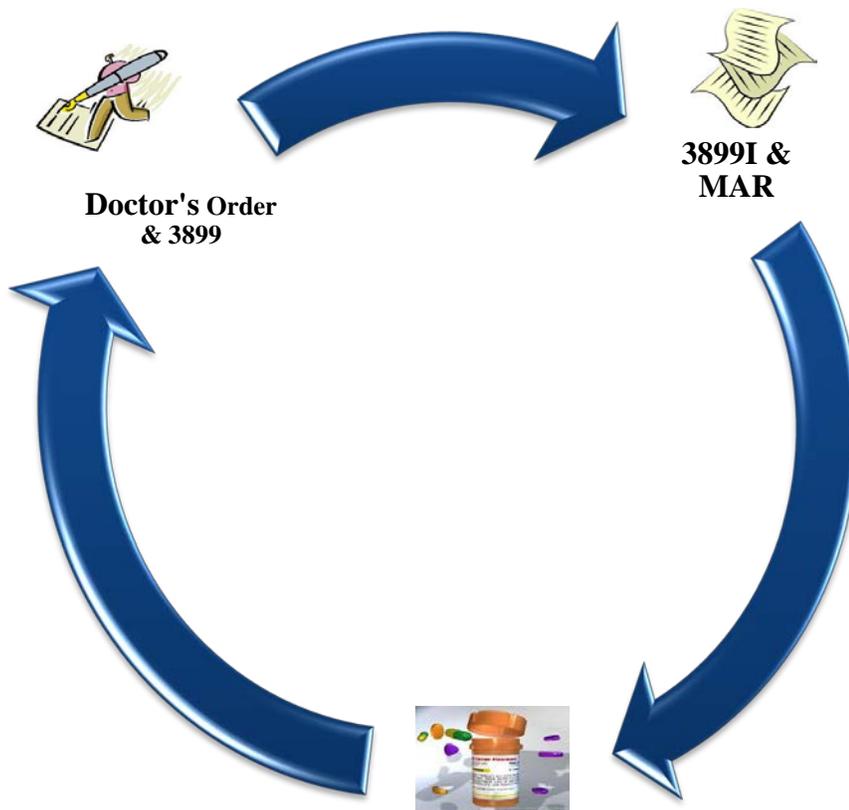
Note:

The AE system uses the AF Form 3899 series to document and provide care. One vital element in the medication administration process involves ensuring the most current medication orders are properly transcribed onto proper forms and the last medication dose given is clearly indicated in **ZULU** to leave no doubt when the next dose will be due.

Reconciliation Points:

- Admission
- Transfer points where orders are re-written
- Discharge/Transfer to another level of care
 - Reconcile with admission list, clarify discrepancies
 - Provide to patient – **ensure patient knows how and when to take meds if self-administered medication (SAM).**
 - For patient entering Patient Movement System:
 - ✎ Reconcile with **AF Form 3899B, Patient Movement Physician Orders**, & **AF Form 3899I, Patient Movement Medication Record**.
 - ✎ Record last dose(s) on AF 3899 in Zulu time (ZULU Time Chart is in AFI 41-307, Figure 1.1).

Reconciliation Graphic:



IMPORTANT CONSIDERATIONS FOR PREPPING A PATIENT FOR THE AE SYSTEM

NOTE: This guide is intended to be used as a quick reference guide.

For more detail or all clarification you must refer to referenced publication or other references provided. Also, utilize proper guidance from the appropriate Patient Movement Requirements Center (PMRC) for clarification of any specific patient prep or validation requirement

RESPONSIBILITY OF THE ORIGINATING MTF (AFI 41-301)

- Transport to and from airfield or staging facilities when directed
- Obtain and transport the appropriate diet for the pt
- Provide appropriate personnel to accompany patients to aircraft
- Help load and unload patients and baggage
- Coordinate with sponsoring agency to provide instructions on correct patient care
- Ensure entry requirements (passport, visa immunizations) are met for country the patient or attendant is transiting through
- Brief patients and attendants thoroughly before departure – where, when & why
- Ensure litter patients who do not wear hospital pajamas wear appropriate conservative seasonal attire (mental health litter pts **must** be in pajamas) & ambulatory patients wear the appropriate service uniform or civilian clothes

REQUIRED PAPERWORK

- ID band from TRAC2ES
- Allergy band
- Inpatient/Outpatient records
- **AF IMT 3899, Patient Movement (PM) Record**, is a legal medical document and part of the patient's permanent medical treatment record (Ref: AFI 41-307, Ch. 1)
 - Signed by VFS clearing pt for flight
 - Current appropriate orders, signed by doctor
 - **3899I (MAR) correctly transcribed** from current orders by MTF or CASF
 - Must reflect the most current medication orders and administration (last dose?)
 - Must provide clear indication when the next dose is due in Zulu
 - **Self medicating pts must have self-administering medication (SAM) clearly indicated in current orders AND SAM box must be marked on 3899A**

A few quick documentation guidelines:

Mandatory - Document all times in **ZULU** (AFI 41-307, Ch 1)

- Anti-hijacking statement: proper anti-hijacking of person and all baggage must be indicated
- If foreign national transiting through AE system ensure all proper documentation is provided (coordinate through PMRC).

LITTER PREP GUIDANCE: (Ref AFI 41-301, Ch 2)

NOTE: *During contingency operations, each patient must be provided, at a minimum, a litter and two litter straps. See AFI 10-2909, Ch 5.)*

The litters (litters approved for flight – not all litters are air-worthy) will be prepared with:

- Mattress.
- Two blankets.
- Two sheets.
- One pillow and pillowcase.

- Two Litter Straps.
- Additional items as required due to patient needs or weather

ENPLANING/ DEPLANING (AFI 11-2AE, V3, Ch 13)

- No smoking within 50 feet of aircraft.
- Identify patients requiring assistance.
- Litter patients may be enplaned / deplaned as ambulatory if **in the professional judgment of the FN** no contraindications exist.
- Ensure that all ambulatory patient personal belongings, to include medications if self-medicating, are in their possession.
- Transfer of physical care is complete once the patient enters or exits the ground vehicle of transportation.
- All female litter mental health patients should be provided with a female attendant during movement between the aircraft and the destination facility - If accompanied by a responsible adult female, attendant, another non-psychiatric female patient, or military sponsor, there is no need for an additional attendant to escort the patient.
- CCATT patients may be positioned with their head towards the flight deck if the CCATT physician determines patient condition warrants head first placement.
- Minimum of a four (4) person carry is required for enplaning/deplaning the following:
 - Lifting a litter patient above waist level.
 - Litter patients of excessive weight or those required to be carried for long distances.
 - Occupied civilian ambulance type stretchers/gurneys.
- A minimum three (3) person carry is required for the following:
 - Enplaning/deplaning a litter patient with a backrest (cannot be in the 90° position)

NOTE: AECMs may revert to a two (2) person carry once inside the aircraft

BAGGAGE & CARRY-ONS (AFI 11-2AE, V3, Ch 13)

- Ensure that all ambulatory patient personal belongings, to include medications if pt is self-medicating, **are in their possession.**
- Accompanied patient baggage will receive expeditious handling and will be processed separately from passenger baggage.
- Anti-hijack inspection of all persons and hand-carried articles transported in the AE system is required - **All baggage requires inspection.**
- Due to space limitations onboard the aircraft, all patients and attendants are limited to one hand-carried item.
- Patients **will not** be permitted access to checked baggage.
- On the C-21, patients and attendants will be limited to one stowed bag **not exceeding 30 lbs.** In addition, one hand carried article (brief case, laptop case, and purse) may be carried - extra baggage carried will be processed by the sending facility into the Traffic Management System.

STRESSES OF FLIGHT CONSIDERATIONS (AFI 41-307, Ch 2):

Patients in the AE environment are more susceptible to physiologic stresses encountered at altitude. These stresses of flight include decreased partial pressure of oxygen, barometric pressure and thermal changes, decreased humidity, noise, vibration, fatigue, and gravitational forces (G-Forces). Below are examples of how these stresses affect the body, which highlights the unique environment of AE.

Decreased partial pressure of O₂:

- With higher altitude, the pressure on all gases, including oxygen, is decreased. This leads to the condition called hypoxia.
- Exacerbates possible oxygenation deficiencies due to the compromised respiratory system and diminished ciliary action.
- Increases myocardial workload, predisposing compromised patients to arrhythmias, chest pain and may lead to myocardial infarction.

Barometric Pressure changes:

- On ascent gas expands and on descent gas contracts.
- Therefore, trapped or partially trapped gases within certain bodily cavities; i.e., the gastrointestinal (GI) tract, lungs, skull, middle ear, sinuses, and teeth expand in direct proportion to the decrease in pressure.
- This increased volume becomes significant as 1 liter of gas at sea level becomes 1½ liters at 9,000 feet.
- May cause spontaneous pneumo-thorax in a trauma patient with significant respiratory compromise.
- GI tract gas expansion may cause diaphragmatic crowding leading to lower tidal volumes.

Thermal Changes:

- An increase in altitude results in a decrease in ambient temperature.
- Aircraft cabin temperature fluctuates considerably depending on the temperature outside the aircraft.
- Heat increases body temperature and cold produces muscle shivering increasing the metabolic rate and O₂ demand on the body; this is particularly true in ventilator dependent patients.
- Excessive heat may cause patients on cardiac medication to become hypotensive
- Hyperthermia and hypothermia may increase cardiac oxygen requirements.

Decreased Humidity:

- When air is cooled, it loses its ability to hold moisture. Air at altitude is cold, possessing very little moisture.
- The higher the altitude, the colder and drier the air; after 2 hours of flying time on a typical flight, there is less than 5% relative humidity; after 4 hours, relative humidity is less than 1%.
- The effectiveness of ciliary action is decreased and secretions are thicker.
- Exacerbates fluid loss.

Noise:

- Unprotected exposure to noise can interfere with effective communications, temporary (auditory fatigue), permanent threshold shifts (sensori-neural hearing loss), and varying levels of fatigue.
- Auditory fatigue incurred by noise is frequently accompanied by a feeling of “fullness,” high-pitched ringing, buzzing, or a roaring sound (tinnitus) in the ears.

Vibration:

- The response to whole body vibration is an increase in muscle activity both to maintain posture and to reduce the resonant amplification of body structures.
- Additionally, disturbances in visual acuity, speech, and fine-muscle coordination result from vibration exposure.
- May increase pain, motion sickness and vomiting.

Fatigue:

- Fatigue is the end product of all the physiological and psychological stresses associated with exposure to altitude
- Most patients with respiratory disorders are already fatigued from the added workload of just breathing
- Cumulative effect of stresses may exacerbate the patient's condition with cardiac issues

Gravitational Forces:

- Acceleration and deceleration are important (G-Force) to consider in AE.
- When the aircraft accelerates or decelerates, already swollen or bruised brain or spinal cord tissue could experience further damage.
- Takeoff may increase returning blood flow and cardiac workload for some patients

A FEW SPECIAL TIPS:

PRE-FLIGHT CONSIDERATIONS (within each section of relevance)

Airway Basics (AFI 41-307, Ch 4)

- Maintain a patent airway with positioning, suctioning, and adequate humidified oxygen
- Assure there will be sufficient O2 available...
 **TIP:** plan for a couple hours of ground time, having too much available is better than running out

Chest tubes (AFI 41-307, Ch 4)

- In normal situations, patients with recently removed chest tubes will not be airlifted until the following conditions are met:
 1. A minimum of 24 hours post chest tube removal
 2. Expiratory and lordotic chest x-ray at least 24 hours post chest tube removal with the interpretation documented in the patient's medical records
NOTE: In contingency operations these requirements may not be feasible
 3. Occlusive dressing is applied to the site where the chest tube was removed
- Unless contraindicated, position on a **backrest** for comfort; pain medication as required
- Ensure chest drainage system is operational & appropriate for flight
 1. Chest drainage units listed in the current AE Equipment Standards are approved for use in-flight
 2. Other drainage units may be acceptable if a one-way valve system is present and conditions for use are followed and a waiver is obtained IAW AFI 10-2909

Cardiac Management (AFI 41-307, Ch 8)

- Use a backrest if on litter
- Assess if patient is free of chest pain, the last episode of chest pain and if it was associated with shortness of breath (SOB), nausea and diaphoresis, and what actions and/or medications are used to relieve pain
- Identify the presence of a pacemaker or implantable cardioverter-defibrillator
- Identify if altitude restriction required

Burn Management (AFI 41-307, Ch 6)

- Patients with 20% TBS or more, should have an IV, NG, and foley catheter in place during all phases of AE
- Ensure burns are dressed with clean, dry, non-constrictive, bulky dressings

Diabetic Management (AFI 41-307, Ch 8)

- Assure correct medications and special diet are onboard and available
- If patient was provided glucometer from facility, verify expiration of supplies
- Annotate last Blood Glucose result and time

Seizure Precautions (AFI 41-307, Ch 9)

- Prepare to use suction, administer high flow O₂

Casts (AFI 41-307, Ch 10)

- Plaster casts should be bi-valved if swelling is expected or if the cast restricts emergency egress and should be at least 48 hrs old

Infection Control (AFI 41-307, Attachment 12)

- All medical personnel in the AE environment will implement Standard Precautions coupled with Transmission Based Precautions and will keep aircrews informed, as required.
- The aircraft is considered a dirty environment. Dressings will be reinforced not changed
- Patient assignment and placement of patients will be determined by the aircrew depending on all diagnoses. It is imperative a thorough patient history be documented on the Patient Movement Request (PMR).
- For details on specific criteria for movement of highly infectious pts see (AFI 41-307, Attachment 12)

TB (See AFI 41-307 Attach 12 figure A12.1 for specific information on patient movement of TB patients)

Criteria for safe transport of TB patients include:

- Negative sputum smears x 3 days
- Chemotherapy x two weeks and improving clinically
- Laryngeal TB—chemotherapy x 30 days
- No cough

Document the results of above in the PMR for patient validation.

Medical personnel transporting non-MDR-TB patients, and all crewmembers and medical personnel transporting MDR-TB and ventilated TB patients will receive a IPPD 90 days post-mission at their local MTF or IAW local policy; results will be forwarded to the PMRC no later than 100 days post-mission. The PMRC will then review and forward personnel mission data to AMC/SGP.

UNIQUE CONSIDERATIONS FOR AE

Anti-hijacking (AFI 13-207, *Preventing and Resisting Aircraft Piracy (Hijacking,)* pg 8-9 and AFI 11-2AE, V3, Ch 7)

- The originating MTF commanders are responsible for anti-hijacking inspection of all patients
- At the aircraft, MTF or ASTS representatives will provide the medical crew director (MCD) with a signed statement listing the names of the individuals searched and stating anti-hijacking measures have been accomplished
- When patients are delivered to the aircraft by civilian sources, the aircrew will perform required inspections prior to loading
- For all AE missions, the MCD is the final authority for determining what items can be carried by/for AE patients

Procedures to follow to Anti-Hijack: (AFI 13-207, *Preventing and Resisting Aircraft Piracy (Hijacking & 41-301 pg 9)*)

- Inspect patients and attendants either with either a hand held or walk through metal detector, X-ray machine, or by a physical check
- Notify security police if you find suspicious items
- Restrict inspected patients and attendants to a holding area
- Redo the inspection for personnel who leave a holding area after you have finished
- Inspect all hand carried items
- Honor requests for visual inspection instead of using X-ray or metal detectors
- Competent, non psychiatric patients may keep items such as small pen knives (3 inch blades or less), shaving razors, or small scissors
- Deny boarding to individuals refusing anti-hijacking inspection.
- Identify any patient or attendant showing suspicious behavior to the medical crew.
- Arrange for guards to accompany prisoner patients to their destination. **Note: Security police provide guards with appropriate travel orders and funding codes.**
- Conduct all inspections with the highest standard of military courtesy.
- Exempt classified materials held by official couriers from inspection

Inform passengers that they can't carry weapons or explosives aboard. If authorized weapons are carried onboard, notify aircrew of seating location of individuals(s) with weapons

Weapons (AMC PAM 11-303, para 5.1)

Weapons and ammunition can be an issue for the AE crew when trying to get patients onto the aircraft. The easiest way to avoid controversy with the AE crew and the other aircrew members is to anti-hijack the individual. To accomplish this, do the following:

- Separate the ammunition from the weapon. The loadmaster or boom operator will secure the ammunition. Make sure the weapon has been CLEARED! Label the weapon CLEARED and identify the owner.
- Remove any explosives from patient and patient's bags/gear prior to boarding the plane.
- If possible, leave ammo/explosives with the unit's weapons courier.

Narcotics Accountability (AFI 41-307, Ch 7; USTRANSCOM Policy letter May 2010)

- The originating military treatment facility (MTF) is responsible for bringing a sufficient quantity of prescribed controlled drugs to the aircraft with the patient.
- When controlled drugs are brought onboard the aircraft, the Medical Crew Director (MCD) and MTF representative together will complete an inventory.
- The count will be recorded on the AF IMT 3899A form.
- Prescribed controlled drugs entrusted to a patient or attendant are considered to be the property of the individual, who is then responsible for safeguarding and administering the drug(s).
- Flight Nurses (FN) will determine if the patient or attendant is competent to safely manage the medications.
- All controlled substances will accompany the patient to the destination MTF.

Note: The aircrew carries minimum amounts of limited medications for emergencies. The originating MTF must send a sufficient amount of all medications prescribed for the patient, to include narcotics, PRNs, and regularly scheduled medications. ACLS medications are carried on all AE missions.

Equipment Safety: (AFI 10-2909 & AFI 11-2AE, V3, Ch 4)

- Air Force AE squadrons only use in-flight medical equipment approved by the Armstrong Laboratory for use in the AE system.
- It is the originating MTFs responsibility to send approved equipment with the patient. Contact a patient movement clinical coordinator (PMCC) at the Patient Movement Requirements Center (PMRC) if:
 1. The patient requires accompanying medical equipment
 2. The referring facility does not have a transport litter

Note: Keep in mind that special equipment may need a waiver, so contact the PMRC as soon as possible as this may be time consuming.

SECTION V – RESOURCES & ATTACHMENTS

RESOURCES

Aeromedical Evacuation POCs:

For questions and guidance on patient preparation contact your unit AE patient admin coordinator or your theater Patient Movement Requirements Center (PMRC):

PMRC -A (CONUS & Global): 312-779-4200

PMRC-E (Europe): 314-480-8040 or 2264

PMRC-P (Pacific): 315-448-1602 or 1603

PMRC-J (AOR): 318-436-4417 or 4418

To submit a patient safety event report related to patient movement, complete a DD Form 2852 and either have it input into TRAC2ES PMQ-R web-based system by the unit Patient Safety Manager or contact AE Patient Safety representatives for assistance.

AFCENT AE Patient Safety: DSN 312-965-3194

CENTCOM AE Patient Safety: DSN 312-529-0346

AMC AE Patient Safety: CONUS- DSN 312-779-6225/6838/6311 or RAMSTEIN-DSN 314-479-4455

PACAF AE Patient Safety: DSN 315-448-1620

Websites with access links:

DOD Patient Safety Program: <http://health.mil/dodpatientsafety.aspx>

AF Medial Logistics: Equipment Catalog and AE status (safe to fly list)

NOTE: Equipment listed as safe to fly may require a waiver, for questions and guidance; contact your appropriate PMRC.

<https://medlog.detrick.af.mil/index.cfm?event=memo.eqcat>

Air Force E-Publishing

<http://www.e-publishing.af.mil/>

HQ AMC/SG COPSA:

<https://eis.af.mil/cs/usafae/sg/SG%20Documents/Forms/AllItems.aspx>

AFMOA and AF Patient Safety Alerts:

<https://vc.afms.mil/AFMOA/default.aspx>

Reference Publications & Forms with access links:

AFI 11-2AE V3: Aeromedical Evacuation Operations Procedures (18 May 2010)

<http://www.e-publishing.af.mil/shared/media/epubs/AFI11-2AEV3.pdf>

AFI 13-207: Preventing and Resisting Aircraft Piracy (Hijacking) (21 June 2010)

AFI 41-307: Aeromedical Evacuation Patient Considerations & Standards of Care
(20 August 2003 – Incorporating Through Change 2, 28 January 2014).

<http://www.e-publishing.af.mil/shared/media/epubs/AFI41-307.pdf>

AFI 41-301: Worldwide Aeromedical Evacuation System (1 August 1996)

<http://www.e-publishing.af.mil/shared/media/epubs/AFI41-301.pdf>

AFI 10-2909: Aeromedical Evacuation Equipment Standards (23 July 2013)

<http://www.e-publishing.af.mil/shared/media/epubs/AFI10-2909.pdf>

AFI 44-165: Administering Aeromedical Staging Facilities (6Nov 2007)

<http://www.e-publishing.af.mil/shared/media/epubs/AFI44-165.pdf>

DD Form 2852:

<http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2852.pdf>

ACRONYM LIST

| | |
|----------------|--|
| AE | Aeromedical Evacuation |
| AEOO | Aeromedical Evacuation Operations Officer |
| AEOT | Aeromedical Evacuation Operations Team |
| AET | Aeromedical Evacuation Technician |
| AFI | Air Force Instruction |
| AMC | Air Mobility Command |
| AMC/SG | Air Mobility Command Surgeon General |
| AMC/SGK | Air Mobility Command, En Route Medical Care Division |
| ARM | Aeromedical Readiness Mission |
| ASF | Air Staging Facility |
| ASTS | Aeromedical Staging Squadron |
| ATC | Air Traffic Control |
| C2 | Command & Control |
| CASF | Contingency Aeromedical Staging Facility |
| CCATT | Critical Care Air Transport Team |
| CDC | Centers for Disease Control |
| COPSA | Clinical Operations & Patient Safety Alerts |
| CRM | Crew Resource Management |
| ERC | En Route Care |
| FCB | Flight Crew Bulletin |
| FCIF | Flight Crew Information File |
| FN | Flight Nurse |
| FS | Flight Surgeon |
| GPMRC | Global Patient Movement Requirement Center |
| I-SBAR | Identify-Situation-Background-Assessment-Recommendation/Request |
| MCD | Medical Crew Director |
| MII | Medical Incident Investigation |
| MTF | Military Treatment Facility |
| NOTAM | Notice to Airman |
| PIC | Pilot In Command |
| PMRC | Patient Movement Requirement Center |
| PMQ-R | Patient Movement Quality-Report |
| RCA | Root Cause Analysis |
| SAM | Self-Administering Medication |
| SG | Surgeon General |
| SII | Special Interest Item |
| TACC | Tanker Airlift Command & Control |
| TPMRC-A | Theater Patient Movement Requirement Center-America |
| USTC | U.S. Transportation Command or USTRANSCOM |
| WHO | World Health Organization |

ATTACHMENT 1 (Front Side)

| PATIENT MOVEMENT EVENT/NEAR MISS REPORT <small>(Information placed on this form is confidential and privileged in accordance with 10 U.S.C. 1102. Do not file or refer to this form in a patient record.)</small> | | | |
|--|---|---|--|
| PRIVACY ADVISORY: When completed, this form contains personally identifiable information and personal health information and should be protected in accordance with DoD 5400.11-R (the DoD Privacy Program). | | | |
| Prepare this form to document events that resulted in or had the potential to result in harm to anyone in the PM system. NOTE: If completed by ASF or other MTF staff follow local MDG incident reporting policy in addition to completing this form. | | | |
| SECTION I - PERSON COMPLETING FORM | | | |
| 1.a. LAST NAME SMITTY | | b. FIRST NAME JIMMY | c. MIDDLE INITIAL P |
| d. GRADE E5 | e. UNIT OF ASSIGNMENT 879 AES | | |
| f. TELEPHONE NUMBER <small>(Include area code)</small> 888-111-2222 | g. EMAIL ADDRESS jpsfakeemailaddress@someplace.com | h. SIGNATURE | |
| i. WITNESSES TO EVENT | | | |
| (1) NAME/GRADE | (2) UNIT OF ASSIGNMENT OR ADDRESS | (3) TELEPHONE | (4) EMAIL ADDRESS |
| SAWIT, EILEEN, 04 | 699 AES, NOWHERE AFB, ZZ | 888-111-2222 | csfakeemailaddress@someplace.c |
| j. PMQ-R GENERATED LOG NUMBER <small>(For PM Safety Manager):</small> | | | |
| SECTION II - GENERAL INFORMATION | | | |
| 2. DATE (YYYYMMDD)/ TIME (Z) OF EVENT 20121231 | 3. LOCATION OF EVENT <small>(Be specific)</small> | | |
| a. MTF: | d. EN ROUTE HOLDING AREA: AMBUS | g. AIRCRAFT <small>(In-flight):</small> | |
| b. ASF/ASTS: | e. GROUND TRANSPORT: | h. OTHER: | |
| c. OTHER RON: | f. AIRCRAFT <small>(Ground):</small> | | |
| 4.a. MAJCOM RESPONSIBLE FOR MISSION AFCENT | | b. SUBMITTING UNIT 999 EAEF | |
| 5. DID THIS EVENT RESULT IN DEATH, NEAR DEATH OR HOSPITALIZATION? <small>(X appropriate block)</small> IF YES, CONTACT THE PMRC AS SOON AS POSSIBLE TO REPORT EVENT. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 6. PERSON AFFECTED OR POTENTIALLY AFFECTED BY THIS EVENT <small>(X appropriate block)</small> <input checked="" type="checkbox"/> PATIENT <input type="checkbox"/> PAX <input type="checkbox"/> CREW <input type="checkbox"/> FACILITY STAFF <input type="checkbox"/> ATTENDANT <input type="checkbox"/> CCATT MEMBER | | | |
| 7. EVENT CATEGORY <small>(X as applicable)</small> | | | |
| a. MEDICATION | <input type="checkbox"/> MEDICATION ERROR | <input type="checkbox"/> NARCOTIC NOT ACCOUNTED FOR | <input type="checkbox"/> SELF MEDICATION ISSUE |
| b. STATUS CHANGE | | | |
| <input type="checkbox"/> AE PROTOCOL USED | <input type="checkbox"/> DEATH IN-FLIGHT | <input type="checkbox"/> SEIZURES | |
| <input type="checkbox"/> ALLERGIC REACTION | <input type="checkbox"/> DEATH WITHIN 24 HOURS | <input type="checkbox"/> SHORTNESS OF BREATH | |
| <input type="checkbox"/> BIRTH | <input type="checkbox"/> DESATURATION | <input type="checkbox"/> SUICIDE | |
| <input type="checkbox"/> CARDIAC/RESPIRATORY ARREST | <input type="checkbox"/> MEDICATION RESPONSE | <input type="checkbox"/> TRANSIENT/MILD STATUS CHANGE | |
| <input type="checkbox"/> CHEST PAIN | | | |
| c. PATIENT PREP | | | |
| <input type="checkbox"/> ATTENDANT ISSUES | <input type="checkbox"/> MEDICATION | <input type="checkbox"/> SUPPLIES | |
| <input type="checkbox"/> DOCUMENTATION OF CARE | <input type="checkbox"/> ORDERS | <input type="checkbox"/> TREATMENT NOT DONE PRIOR TO FLIGHT | |
| <input checked="" type="checkbox"/> EQUIPMENT | <input type="checkbox"/> PAPERWORK | | |
| d. OTHER | | | |
| <input type="checkbox"/> AIRCRAFT AMPERAGE | <input type="checkbox"/> COMMUNICATION | <input type="checkbox"/> NO MEALS SUPPLIED | |
| <input type="checkbox"/> AIRCRAFT EMERGENCY | <input type="checkbox"/> FLIGHT CREW EQUIPMENT/MSN DUTY | <input type="checkbox"/> PMRC | |
| <input type="checkbox"/> AIRCRAFT MAINTENANCE DELAY | <input type="checkbox"/> INDIVIDUAL BODY ARMOR | <input type="checkbox"/> TRANSPORTATION ISSUES | |
| <input type="checkbox"/> BAGGAGE ISSUES | <input type="checkbox"/> MEDICAL DELAY | | |
| e. PATIENT HANDOFF | <input type="checkbox"/> INADEQUATE PATIENT HANDOFF | <input type="checkbox"/> NO PATIENT HANDOFF | |
| f. INFECTION CONTROL | <input type="checkbox"/> BLOOD OR OTHER BODY FLUID EXPOSURE | <input type="checkbox"/> TRANSPORTATION OF INFECTIOUS PATIENT | |
| g. ASF/RON SPECIFIC | <input type="checkbox"/> ASF/RON TRANSPORTATION ISSUES | | |
| h. ANTI-HIJACK | <input type="checkbox"/> COMPLETED INCORRECTLY | <input checked="" type="checkbox"/> NOT COMPLETED | |
| i. INJURY | <input type="checkbox"/> ACTUAL | <input type="checkbox"/> POTENTIAL | |
| j. EQUIPMENT | | | |
| TYPE OF EQUIPMENT IVAC INFUSION PUMP | | MODEL NUMBER/SERIAL NUMBER <small>(If applicable)</small> IVAC Medsystem III. S/N: 123456789 | |
| <input type="checkbox"/> NOT APPROVED FOR FLIGHT | <input type="checkbox"/> WAIVER REQUIRED | <input type="checkbox"/> FAILURE/MALFUNCTION | |

DD FORM 2852, FEB 2011

PREVIOUS EDITION IS OBSOLETE.

Adobe Professional 8.0

ATTACHMENT 1 (Reverse Side)

| SECTION III - MISSION INFORMATION | | | | | | | | |
|---|---|---------------------------|--|---------------------------------|----------------------------------|---|-------------------------------------|-----|
| 8. MISSION ID NUMBER ZAQ123RF4578 | 9. AIRCRAFT TYPE/ TAIL NUMBER 34567 | 10. EN-PLANE ICAO OALX | 11. DE-PLANE ICAO ETAR | 12. ORIGINATING FACILITY BAF | 13. DESTINATION FACILITY LANS | 14. CCATT ONBD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| SECTION IV - PERSON AFFECTED | | | | | | | | |
| 15.a. LAST NAME FIXIN | b. FIRST NAME NED | c. AGE 32 | d. SEX M | e. STATUS | f. GRADE E3 | | | |
| 16. CITE NUMBER 999999999 | 17. UNIT OF ASSIGNMENT 10TH MTN | | | | | | | |
| 18. PATIENT CLASS | 19. MOVEMENT PRECEDENCE (<i>X one</i>) <input type="checkbox"/> U <input type="checkbox"/> P <input checked="" type="checkbox"/> R | | | | | | | |
| 20. CONTACT INFORMATION OF PERSON AFFECTED | | | | | | | | |
| a. ADDRESS (<i>Include ZIP code</i>) 5687 Nota St Nowhere, FZ, 12345 | | | b. TELEPHONE NUMBER (<i>Include area code</i>) (444)555 | | | | | |
| | | | c. E-MAIL ADDRESS notaaddress@ubet.com | | | | | |
| 21. DIAGNOSIS | | | | | | | | |
| RENAL FAILURE | | | | | | | | |
| 22. MEDICAL EVALUATION TREATMENT RECEIVED (<i>X and complete as applicable</i>) | | | | | | YES | NO | N/A |
| a. DID THE PERSON RECEIVE A MEDICAL EVALUATION AND/OR TREATMENT FOLLOWING THE EVENT? | | | | | | | <input checked="" type="checkbox"/> | |
| b. WAS THE PERSON EVALUATED AND/OR TREATED BY A PHYSICIAN ON THE AIRCRAFT OR FLIGHT LINE? | | | | | | | <input checked="" type="checkbox"/> | |
| IF YES, CREDENTIALLED HEALTHCARE PROVIDER NAME: | | | | | | | | |
| c. WAS THE PERSON EVALUATED AND/OR TREATED AT THE MTF? | | | | | | | <input checked="" type="checkbox"/> | |
| IF YES, MTF NAME AND LOCATION: | | | | | | | | |
| d. IF EVALUATION OR TREATMENT WAS RECOMMENDED, WAS IT REFUSED? | | | | | | | <input checked="" type="checkbox"/> | |
| SECTION V - ASSESSMENT | | | | | | | | |
| 23. EVENT CLASSIFICATION (<i>X as applicable</i>) | | | | | | | | |
| <input type="checkbox"/> | a. EVENT RESULTING IN THE DEATH, NEAR DEATH OR MAJOR PERMANENT LOSS OF FUNCTION. | | | | | | | |
| <input type="checkbox"/> | b. EVENT RESULTING IN TEMPORARY PATIENT HARM AND INITIAL OR PROLONGED HOSPITALIZATION. | | | | | | | |
| <input type="checkbox"/> | c. EVENT RESULTING IN TEMPORARY PATIENT HARM AND EMERGENCY EVALUATION AND/OR TREATMENT. | | | | | | | |
| <input type="checkbox"/> | d. EVENT DID NOT RESULT IN PATIENT HARM, BUT INCREASED MONITORING REQUIRED. | | | | | | | |
| <input checked="" type="checkbox"/> | e. EVENT DID NOT RESULT IN PATIENT HARM OR NEED FOR INCREASED MONITORING. | | | | | | | |
| <input type="checkbox"/> | f. EVENT DID NOT REACH PATIENT AND DID NOT RESULT IN PATIENT HARM. | | | | | | | |
| 24. DESCRIPTION OF EVENT (<i>Concise, factual, objective statement</i>) | | | | | | | | |
| <p>AECM (CMT) went to the AMBUS at Bagram Airfield to brief patients on AMBUS for flight related information. It was determined this patient was not anti-hijacked because he was not listed on the anti-hijacking statement. Patient and his baggage was anti-hijacked IAW AFI 11-2AE, V3 by CMT and ASF personnel.</p> <p>AECM (CMT) noted on the AMBUS during pre-flight checks of patients and their subsequent medical equipment that this same patient had an IVAC (Medsystem III. S/N: 123456789) in place; however, the ASF did not bring the electric cord. ASF personnel had to return to ASF and retrieve cord and return to aircraft.</p> <p>In total these two things caused for a delayed take-off. Patient's affect appeared to tolerate delays in an appropriate manner. AECM (MCD) discussed with ASF NOD that those items/tasks are critical to on-time take-offs and patient movement. ASF NOD appeared receptive.</p> | | | | | | | | |
| 24.a. IMMEDIATE ACTIONS TAKEN | | | | | | | | |
| | | | | | | | | |

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ATTACHMENT 2

AE Patient Movement Classifications: (Ref: AFI 41-307, PG 15)

Psychiatric Classifications. (Ref AFI 41-307: Refer to **Attachment 6**, Mental Health/Behavior Management for more in-depth information)

- **1A** – Severely ill psychiatric patient, who requires close supervision, should arrive at the aircraft in hospital clothing, sedated, and restrained on a dressed litter.
- **1B** – A moderate to severely ill psychiatric patient who is sedated, should wear hospital clothing, and is transported on a litter. Restraints are not applied but one set is secured to the litter or maintained by the patient's medical attendant.
- **1C** – A cooperative, reliable, and moderately severe psychiatric inpatient traveling in ambulatory status, dressed in uniform or civilian clothes.

Litter Categories. (**Litters must be provided by the MTF or CASF**)

- **2A** – A litter patient who may not or cannot ambulate, and may be unable to perform self-care. Requires assistance in the event of an emergency. Travels in hospital clothing and may sit in a seat.
- **2B** – A litter patient, usually dressed in hospital clothing, able to ambulate and sit in a seat, and should be able to ambulate unassisted in the event of an emergency.
- **4D** - **Infant** under 3 years of age on a litter.
- **5D** – Outpatient on litter for comfort or safety going for treatment.
- **5E** – Returning outpatient on a litter for comfort or safety.

Ambulatory Categories.

- **3A** – Inpatient non-psychiatric, non-substance abuse patient requiring medical treatment, assistance or observation en route (usually minimal), or returning from an inpatient visit at a medical facility.
- **3B** – Recovering inpatient, returning to home station, and requires no medical attention en route.
- **3C** – Ambulatory drug or alcohol substance abuse inpatient going for treatment dressed in military or civilian clothing.

Infant Categories.

- **4A** - Infant, less than 3 years of age, occupying a seat and going for treatment.
- **4B** - Infant, less than 3 years of age, occupying a seat and returning from treatment.
- **4C** - Infant requiring an Airborne Life Support System (ALSS).
- **4E** - Outpatient under 3 years of age occupying a seat.

Outpatient Categories.

- **5A** Outpatient ambulatory going for treatment. Does not require a litter or medical assistance during flight.
- **5B** – Outpatient ambulatory drug or substance abuse patient going for treatment.
- **5C** – Psychiatric outpatient going for treatment.
- **5D** – Outpatient on litter for comfort or safety going for treatment.
- **5E** – Returning outpatient on a litter for comfort or safety.
- **5F** – Returning outpatient

Attendant Categories.

- **6A** – Medical Attendant (MA). A physician, nurse, or technician who is assigned to provide specialized medical/nursing treatment en route through to the patient's destination facility.
- **6B** – Non medical attendant (NMA).

ATTACHMENT 3

| PATIENT TRANSFER CHECKLIST (not all inclusive; tailor to individual patients) | | Date _____ |
|--|---|-------------|
| Patient Name _____ | Cite # _____ | MSN # _____ |
| <p><u>Initial each item after ensuring each item is complete</u></p> <p>____ Patient Identification Band (Rt wrist as appropriate)</p> <p>____ Allergy Band (Rt wrist as appropriate)</p> <p>____ Military Identification Card</p> <p>____ Passport, as required</p> <p>____ Orders (military)</p> <p>____ Medical Records/X-Rays</p> <p>____ Medication (documented last doses given on AF 3899I)</p> <p>____ If on litter, litter mattress, clean sheets, blankets and two litter straps</p> <p><u>AF IMT 3899 – Patient Movement Record Series</u></p> <p>____ Narrative Summary</p> <p>____ Patient weight (Green canvas NATO litter max 250 lbs, Green/Black DECON Litter max 350 lbs; if greater use OWL)</p> <p>____ En route medical/special equipment approved for flight or waiver requested/approved by AMC</p> <p>____ Appropriate Physician Treatments/Medications Ordered</p> <p><u>AF IMT 3899A – Patient Movement Progress Note and Appropriate AF IMT 3899 series</u></p> <p>____ Documentation of all patient care en counters, (Vital Signs, Intake/Output Totals)</p> <p>____ Risks for hypoxia en route (O2 for ground/rotor transport, ventilator, suction). Consider O2 order.</p> <p>____ Vital Signs/Temperature within normal limits **</p> <p>____ Pain Assessment and adequate amount of medications**</p> <p>____ Risk for Skin Breakdown (use litter mattress, occipital "donut"); turn every 2 hours **</p> <p>____ Bowel/Bladder toileting documented; urinary catheter if unable to void while on litter</p> <p>____ Colostomy/Ileostomy/urinary drainage bag clean/empty **</p> <p>____ External fixator pin care **</p> <p>____ Plaster casts should be 48 hours old and bivalved**</p> <p>____ Adequate circulation/neuro status of all extremities**</p> <p>____ Risks for DVT; prophylaxis considered</p> <p>____ Dressing clean/dry/negative pressure device</p> <p>____ Dressings changed within 12 hours of transport **</p> <p>____ IV tubing changed within 48 hours of transport **</p> <p>____ IV catheter changed within 48 hours of transport and patent</p> <p>____ IVs labeled/timed/on pump**</p> <p>____ Fluids/meals as required; if NPO, IV fluids maintained</p> <p>____ Infection Control Precautions (Contact Precautions required for all combat wounds)</p> <p>____ Hot/Cold Weather factors addressed, including appropriate footwear</p> <p>____ Controlled Drug Accountability ** (** - documented)</p> | <p><u>AF IMT 3899I – Patient Movement Medication Record</u></p> <p>____ Self Administration of Medication (SAM): orders, knows use and documented (AF 3899) (outpatient only)</p> <p>____ Sufficient medication for the continuum, matches PMR and physician orders. Last doses documented</p> <p>____ Sufficient IV solutions for the continuum, matches PMR and physician orders</p> <p>____ IV medication labeled/timed/on pump</p> <p>____ Plan for administering schedule medications/drips during ground/rotor transport</p> <p><u>Patient's Property:</u></p> <p>____ Weapons, explosives, lighters, matches identified/removed</p> <p>____ Knives removed from patient's control and inventoried. Use AF Form 3854, Receipt of Valuables, and AF Form 1053, Record of Patient Storing Valuables or Service Specific List</p> <p>____ Items in excess of 60 pounds are inventoried and transportation is arranged by patient's service representative</p> <p>____ Thorough anti-hijacking search of person and bags, and written Anti-hijacking Certification complete</p> <p>____ Psychiatric Patients</p> <p>____ Search all baggage and person for sharps, matches, lighters and cigarettes, and medication</p> <p>____ Items not allowed will be inventoried and accounted for as above</p> <p>____ Litter (1A/1B) patients should travel in hospital clothing with a medical attendant; may carry eyeglasses, toothbrush, and a small amount of money (not to exceed \$25.00), wedding band, rings, wristwatch, ID card, and wallet.</p> <p>____ Leather Restraints IAW AF IMT 3899F, Patient Movement Physician Orders for Behavior Management and Restraints, and start AF IMT 3899G, Patient Movement Restraint Observation Flow sheet</p> <p>____ Leather Restraints (not secured to litter)</p> <p><u>Medical Attendant/Non-Medical Attendant</u></p> <p>____ Appropriate skill level healthcare provider; same sex if accompanying psychiatric patients</p> <p>____ Coordinated/approved by PMRC</p> <p>____ Military ID</p> <p>____ Original deployment and travel orders to return to the AOR</p> <p>____ Personal items/baggage IAW theater policy (carry on, duffel)</p> <p>____ Received Point of Contacts for arrival and departure, and planned itinerary/tickets back to duty station</p> <p>____ No weapons, explosives, knives/sharp objects, matches or lighters</p> <p>____ Thorough anti-hijacking search of person and bags, and written</p> <p>____ Aware of duties/responsibilities to assigned patient/s</p> | |
| <p>ORIGINATING FACILITY</p> <p>Printed Name _____</p> <p>Signature _____</p> | <p>VERIFICATION (i.e. ASF/CASF Staff)</p> <p>Printed Name _____</p> <p>Signature _____</p> | |

ATTACHMENT 4 (Front Side)

AEROMEDICAL EVACUATION (AE) PATIENT HANDOFF CHECKLIST

Attachment 1

| | DATE/TIME: | CITE #: | PATIENT NAME: | AGE: | RANK: |
|--------------------------|--|---------|---------------------|------|-------------------------|
| I | CURRENT SENDING FACILITY: | | RECEIVING FACILITY: | | PATIENT CLASSIFICATION: |
| (Identify) | HANDOFF TO AE CREW BY FACILITY | | REPORT BY: | | |
| S (Situation) | Diagnosis: _____ Date of surgery: _____ Date of injury/admission: _____ Current status: <input type="checkbox"/> Alert/Oriented <input type="checkbox"/> Confused/Disoriented <input type="checkbox"/> Responds to verbal <input type="checkbox"/> Responds to pain <input type="checkbox"/> Unconscious Patient on/offload method: <input type="checkbox"/> Unassisted <input type="checkbox"/> Crutches/cane <input type="checkbox"/> Litter Code status: <input type="checkbox"/> DNR Attendant: <input type="checkbox"/> Medical <input type="checkbox"/> Non-medical Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List: _____ Medications: <input type="checkbox"/> None <input type="checkbox"/> Self-Administered <input type="checkbox"/> Given to Flight Nurse <input type="checkbox"/> See 3899 for list Recent: Pain Meds/Route/Time Given (zulu) _____ Antiemetic/Route/Time Given (zulu) _____ Antibiotics/Route/Time Given (zulu) _____ Other Meds/Route/Time Given (zulu) _____ | | | | |
| B (Background) | Other pertinent information/history: _____ | | | | |
| A (Assessment) | Vitals: BP _____ P _____ R _____ SpO2 _____ T _____ Pain level: _____/10 Location: _____ Airway: <input type="checkbox"/> No devices <input type="checkbox"/> Trach <input type="checkbox"/> Other: _____ Breathing: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Labored <input type="checkbox"/> Assisted Oxygenation: <input type="checkbox"/> Room Air <input type="checkbox"/> NC <input type="checkbox"/> NRB Rate: _____ LPM Circulation: <input type="checkbox"/> Adequate <input type="checkbox"/> Altered (location): _____ Skin: <input type="checkbox"/> Skin Intact/No Pressure Ulcers (PU) or concerns IV: <input type="checkbox"/> PU Location/Braden Scale Score: _____ Rate: _____ mL/hour <input type="checkbox"/> 0.9% NS <input type="checkbox"/> LR <input type="checkbox"/> D5W <input type="checkbox"/> Other: _____ <input type="checkbox"/> Packed RBCs <input type="checkbox"/> Saline Lock Location: _____ <input type="checkbox"/> Fluids brought onboard w/ patient <input type="checkbox"/> Tubing/Fluids/medications labeled Devices: <input type="checkbox"/> Suction <input type="checkbox"/> Orthopedic device <input type="checkbox"/> NG tube <input type="checkbox"/> Pt Monitor <input type="checkbox"/> Restraints <input type="checkbox"/> Foley <input type="checkbox"/> Chest tube <input type="checkbox"/> IV pump <input type="checkbox"/> Cast <input type="checkbox"/> Neg Pressure Wound Therapy Device(s) x _____ <input type="checkbox"/> SCDS <input type="checkbox"/> Feeding tube <input type="checkbox"/> Drain <input type="checkbox"/> Epidural <input type="checkbox"/> PCA pump <input type="checkbox"/> Peripheral Nerve Block <input type="checkbox"/> Other: _____ Pain equipment safety check: <input type="checkbox"/> Site: _____ <input type="checkbox"/> Line patent <input type="checkbox"/> Pump functional <input type="checkbox"/> Right Medication/concentration <input type="checkbox"/> Right infusion rate/settings <input type="checkbox"/> Tubing unclamped Wound vac safety check: <input type="checkbox"/> Site(s): _____ <input type="checkbox"/> Tube unclamped <input type="checkbox"/> Pump functional Abnormal labs: <input type="checkbox"/> H/H <input type="checkbox"/> Cardiac enzymes Other pertinent information: _____ Specific Inflight orders/instructions for AE Crew (AF 3899, Section III, Other Orders): _____ | | | | |
| R | (Recommendation/Request) Standard Patient Preparation Items Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No ** See back of checklist** Inflight orders/instructions accomplished <input type="checkbox"/> Yes <input type="checkbox"/> No Other information: _____ | | | | |
| S (Situation) | HANDOFF BY AE CREW REPORT BY: <input type="checkbox"/> No change in status/situation Status change: <input type="checkbox"/> A/O <input type="checkbox"/> Confused <input type="checkbox"/> Verbal <input type="checkbox"/> Pain <input type="checkbox"/> Unconscious Pt offload method: <input type="checkbox"/> Unassisted <input type="checkbox"/> Crutches/cane <input type="checkbox"/> Litter Other information: _____ <input type="checkbox"/> No change in medication Inflight: _____ Last Pain Meds/Route/Time Given (zulu) _____ Last Antiemetic/Route/Time Given (zulu) _____ Last Antibiotics/Route/Time Given (zulu) _____ Other Meds/Time Given (zulu) _____ | | | | |
| B (Background) | Other information: _____ | | | | |
| A (Assessment) | Last Vitals: BP _____ P _____ R _____ SpO2 _____ T _____ Pain level: _____/10 Location: _____ Airway: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ Breathing: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ Oxygenation: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ at _____ LPM Circulation: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ Skin: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ at _____ mL/hour IV: <input type="checkbox"/> No change <input type="checkbox"/> Changed to: _____ at _____ mL/hour Devices: <input type="checkbox"/> No change <input type="checkbox"/> Changed to/Issues during flight: _____ Device safety checks completed: <input type="checkbox"/> Yes <input type="checkbox"/> No* * If "No" is checked, please explain why below. Other information: _____ | | | | |

AF IMT 38990, 20130701, VI (page 1 of 2) PERSONAL DATA, Privacy Act 1974 (5 U.S. C. 552a), 01 August 2000 AFVA 205-15
 * This form is not a part of the patient's permanent medical record

ATTACHMENT 4 (Reverse Side)

AEROMEDICAL EVACUATION (AE) PATIENT HANDOFF CHECKLIST (BACKSIDE)
STANDARD PATIENT PREPARATION ITEMS
(TO BE COMPLETED BY THE ORIGINATING FACILITY/CASF/ASF PRIOR TO ARRIVING AT THE AIRCRAFT)

| TASK | DESCRIPTION | SUPPORTING REGULATION |
|--|--|--|
| Medication <input type="checkbox"/> N/A | <p>Role 2 to Role 3 (i.e. Bastion to Bagram) movements in combat operations theater: 1-day minimum;</p> <p>Role 3 to Role 4 (i.e. Bagram to LRM(C) movements: 2-day minimum; inpatients from OCCONUS MTF to port of entry MTF CONUS (i.e. LRM(C) to Bethesda): 2-day minimum; inpatients from OCCONUS MTF to other locations in CONUS with RON: 3-day minimum; all outpatient movements OCCONUS to CONUS: 5-day minimum; CONUS to CONUS movements: 1-day minimum.</p> <ul style="list-style-type: none"> • Pain medication within 1 hours of departure (if applicable) • Antiemetic (if applicable) • Medication that would be scheduled to be given during patient loading and through 1 hour after takeoff (if applicable) <p><input type="checkbox"/> Patient is pre-medicated prior to flight</p> <p><input type="checkbox"/> Patient medication verified</p> | <p>AFI 44-165, <i>Administering Aeromedical Staging Facilities</i>, para 2.5.3., 2.10.3.1., 2.10. 2.10.4, 2.10.7., 2.12.5.; USTRANSCOM Memorandum, <i>Medication Administration, Self-Medicating Patients and Controlled Substance Accountability within the Patient Movement System</i>, dated 17 May 2010.</p> |
| Equipment <input type="checkbox"/> N/A | <p>Equipment must work properly and battery must be fully charged prior to leaving facility.</p> <p>Originating MTF must use only flight-certified medical equipment for use on AE missions. All "approved equipment" questions must be directed to GPMRC or appropriate theater AECC/TPMRC.</p> <p>Power cords/adapters, canisters, filter brackets/securing device, tubing</p> <p><input type="checkbox"/> Working condition confirmed</p> <p><input type="checkbox"/> Approved for flight</p> <p><input type="checkbox"/> Equipment waiver obtained</p> <p><input type="checkbox"/> All auxiliary parts present</p> | |
| Supplies <input type="checkbox"/> N/A | <p>Role 2 to Role 3 (i.e. Bastion to Bagram) movements in combat operations theater: 1-day minimum;</p> <p>Role 3 to Role 4 (i.e. Bagram to LRM(C) movements: 2-day minimum; inpatients from OCCONUS MTF to port of entry MTF CONUS (i.e. LRM(C) to Bethesda): 2-day minimum; inpatients from OCCONUS MTF to other locations in CONUS with RON: 3-day minimum; all outpatient movements OCCONUS to CONUS: 5-day minimum; CONUS to CONUS movements: 1-day minimum.</p> | <p>AFI 44-165, <i>Administering Aeromedical Staging Facilities</i>, para 2.6.3., 2.10.7.; USTRANSCOM Memorandum, <i>Medication Administration, Self-Medicating Patients and Controlled Substance Accountability within the Patient Movement System</i>, dated 17 May 2010.</p> |
| Documentation | <p><input type="checkbox"/> Documentation verified</p> <ul style="list-style-type: none"> • Physician has signed the AF 3899/DD Form 602 • Flight surgeon has cleared the patient; documented on form • AF Form 3899/DD Form 602, medical record, x-rays placed in an envelope affixed with completed DD Form 2267 or with the following information: patient's name, rank/status, SSN, nationality (if not a US citizen), organization, date of departure, and destination) • Military ID card with the patient or in envelope listed above • ID bracelet on patient with last name, first name, middle initial, cite #, and date of birth | <p>AFI 44-165, <i>Administering Aeromedical Staging Facilities</i>, para 2.2.8.1.5., 2.5.3., 2.9., 2.10.7., 2.12.5.; USTRANSCOM Policy Letter, dated 9 October 2009.</p> |
| Anti-hijacking/Baggage | <p><input type="checkbox"/> Completion confirmed</p> <ul style="list-style-type: none"> • Patients, attendants, and their baggage are inspected with a hand-held or walk-through metal detector, x-ray machine, or physical check for weapons or explosives. • All baggage is tagged appropriately and baggage manifest is provided to the AE crew. | <p>AFI 44-165, <i>Administering Aeromedical Staging Facilities</i>, para 2.8.2.1., 2.8.1.5., 2.12.4.2., 2.13.</p> |

ATTACHMENT 5 (Front and Back)

AEROMEDICAL EVACUATION OUTPATIENT PATIENT HANDOFF CHECKLIST

| | |
|---|--|
| <p>Pt Name: _____ DOB: _____ Age: _____ Classification: _____ Diagnosis: _____ AF 3899 signed by FS: Y / N Preflight VS: BP _____ P _____ R _____ SaO2 _____ T _____ Pain _____ /10 Location: _____ Allergies: _____ Medical Attendant: Y / N Non-medical Attendant: Y / N Inpt Records: Y / N Outpt Records: Y / N CD: Y / N Is patient a SAM? Y / N Narcotics: Y / N Medications: _____ Next Medication(s) due: _____ Date of injury/surgery & procedure: _____ Last dressing change: _____ Saline Lock: Y / N Location: _____ O2 requirements _____ Diet: NPO / regular / full liquid / clear liquid / cardiac / low Na / diabetic / other _____ Equipment: Litter / IV pump / suction / backrest / glucometer / other _____ Ambulatory Device: crutches / cane / walker / walking cam boot / other _____ If applicable, date last seizure / chest pain / ETOH intake / Glucose _____ Other pertinent info/treatments/labs: _____</p> | <p style="text-align: center;"><u>AE CREW</u></p> <p><input type="checkbox"/> NO CHANGE</p> <p><input type="checkbox"/> CHANGE SUMMARY (please refer to patient record):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
| <p>Pt Name: _____ DOB: _____ Age: _____ Classification: _____ Diagnosis: _____ AF 3899 signed by FS: Y / N Preflight VS: BP _____ P _____ R _____ SaO2 _____ T _____ Pain _____ /10 Location: _____ Allergies: _____ Medical Attendant: Y / N Non-medical Attendant: Y / N Inpt Records: Y / N Outpt Records: Y / N CD: Y / N Is patient a SAM? Y / N Narcotics: Y / N Medications: _____ Next Medication(s) due: _____ Date of injury/surgery & procedure: _____ Last dressing change: _____ Saline Lock: Y / N Location: _____ O2 requirements _____ Diet: NPO / regular / full liquid / clear liquid / cardiac / low Na / diabetic / other _____ Equipment: Litter / IV pump / suction / backrest / glucometer / other _____ Ambulatory Device: crutches / cane / walker / walking cam boot / other _____ If applicable, date last seizure / chest pain / ETOH intake / Glucose _____ Other pertinent info/treatments/labs: _____</p> | <p style="text-align: center;"><u>AE CREW</u></p> <p><input type="checkbox"/> NO CHANGE</p> <p><input type="checkbox"/> CHANGE SUMMARY (please refer to patient record):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
| <p>Pt Name: _____ DOB: _____ Age: _____ Classification: _____ Diagnosis: _____ AF 3899 signed by FS: Y / N Preflight VS: BP _____ P _____ R _____ SaO2 _____ T _____ Pain _____ /10 Location: _____ Allergies: _____ Medical Attendant: Y / N Non-medical Attendant: Y / N Inpt Records: Y / N Outpt Records: Y / N CD: Y / N Is patient a SAM? Y / N Narcotics: Y / N Medications: _____ Next Medication(s) due: _____ Date of injury/surgery & procedure: _____ Last dressing change: _____ Saline Lock: Y / N Location: _____ O2 requirements _____ Diet: NPO / regular / full liquid / clear liquid / cardiac / low Na / diabetic / other _____ Equipment: Litter / IV pump / suction / backrest / glucometer / other _____ Ambulatory Device: crutches / cane / walker / walking cam boot / other _____ If applicable, date last seizure / chest pain / ETOH intake / Glucose _____ Other pertinent info/treatments/labs: _____</p> | <p style="text-align: center;"><u>AE CREW</u></p> <p><input type="checkbox"/> NO CHANGE</p> <p><input type="checkbox"/> CHANGE SUMMARY (please refer to patient record):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
| <p>Pt Name: _____ DOB: _____ Age: _____ Classification: _____ Diagnosis: _____ AF 3899 signed by FS: Y / N Preflight VS: BP _____ P _____ R _____ SaO2 _____ T _____ Pain _____ /10 Location: _____ Allergies: _____ Medical Attendant: Y / N Non-medical Attendant: Y / N Inpt Records: Y / N Outpt Records: Y / N CD: Y / N Is patient a SAM? Y / N Narcotics: Y / N Medications: _____ Next Medication(s) due: _____ Date of injury/surgery & procedure: _____ Last dressing change: _____ Saline Lock: Y / N Location: _____ O2 requirements _____ Diet: NPO / regular / full liquid / clear liquid / cardiac / low Na / diabetic / other _____ Equipment: Litter / IV pump / suction / backrest / glucometer / other _____ Ambulatory Device: crutches / cane / walker / walking cam boot / other _____ If applicable, date last seizure / chest pain / ETOH intake / Glucose _____ Other pertinent info/treatments/labs: _____</p> | <p style="text-align: center;"><u>AE CREW</u></p> <p><input type="checkbox"/> NO CHANGE</p> <p><input type="checkbox"/> CHANGE SUMMARY (please refer to patient record):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |

LAST PAGE