MEDSERVEWALES

Activity Report

Week commencing: 27th December 2021

Team Shift Activity:	number of shifts:	1
	number of taskings:	4
	number of patient involvements:	4
	number of governance procedures:	2

Team Shift:

Date:	31/12	**Duration:**	?	**Personnel:**	IB, CM, RL
No. of taskings	4				
trauma	1	*adult*	4		
medical	1	*paediatric*	0		
cardiac arrest	2				

Pre-shift issues	nil	**Post-shift issues**	not submitted
Pre-comments	nil	**Post-comments**	not submitted

Case	Age	gender	type	Job description	S/D	Scene time	Total time	General interventions	Governance interventions	Adverse events
1	50	male	medical	Known epilepsy, Fit outside, banged head	no	-	-	no	no	nil
	Additional comments:			GCS 14 Abrasion crown of head, Pupils nad Epilepsy reasonably well controlled BM 14 Advised see GP Alloc 18:27, Scene18:47, Clear 19:15						

2	36	male	trauma	Jumped in front of car	no	-	-	no	no	nil
	Additional comments:			Painful lower Left leg ["IV access"] ["Limb splinting"] Fentanyl 100mcg, Ondanseton 4mg, Paracetamol 1g Alloc 19:16, Scene 19:18, Clear 20:02						
3	74	male	arrest	Collapse ? Cardiac arrest	no	00:49	02:21	yes	yes	nil
	Additional comments:			On EMS arrival CPR in progress Good pulse, good resps but GCS 4 ICD in situ, CABG 2000 ["IV access"] RSI, Extrication, Tx to UHW **["PHEA"]** timings: decision 21:05, start 21:38, complete 21:43 indication: Airway compromise - low GCS location: ambulance team: intubator – RL, drugs – IB, airway assist - CM full checklist, pre-O2 meds: diazepam, fentanyl 50mcg, ketamine 100mg, rocuronium 100mg intubation: RL, DL-4, Grade 1, 2nd attempt, #8.0, 24cm, bougie used confirmation: ["misting","chest movement","auscultation","etCO2"] ventilator within 2 mins complications: nil post-drugs: rocuronium 50mg observations stable transferred to UHW						
4	57	female	arrest	Fall top to bottom of stairs.	no	01:11	01:19	yes	yes	nil
	Additional comments:			Partner heard bangs, found pt at bottom of stairs, not breathing. Neighbour called as nurse - 999 call made						

		["IV access","IO access","Advanced life support"] ["Ultrasound (cardiac)"] SP, APP and EA crew on scene. Lucas on, iv access being attempted, airway soiled, no co2 and no chest movement, asystole. DR01 - HOTT, LUCAS removed, IB ETT, CM bilateral thoracotomies (lungs up), pelvic binder applied, iv access x2 and saline running. Reassess - PEA 45bpm narrow complex. Ultrasound - minimal cardiac movement, very poor ventricular contraction with no meaningful output, no tamponade Fluids continued with CPR. Discussion risks v benefits of moving as near hospital, massive boggy mass at the back of head with blood pouring from ears and nose ?basal skull / intracranial bleed as primary cause. Rhythm became slow / agonal with no cardiac movement. ROLE @0152hrs. Good WAST /medserve response. **["Simple Thoracostomy"]** operators: CM location: domestic indication: traumatic arrest procedure: bilateral, lungs up complications: nil

key – Res = responder, S/D = stood down?, time = hour:mins

Solo Activity:

active responders: SB 5854

number of taskings: 2

number of patient involvements: 2

number of governance procedures: 1 EMRTS

Tasking Types:

trauma	2	*adult*	2
medical	0	*paediatric*	0
cardiac arrest	0		

Case	Res	Date	Age	gender	type	Job description	S/D	Scene time	Total time	General interventions	Governance interventions	Adverse events
1	SB5854	27/12		male	trauma	RTC	no	-	-	yes	no	nil
				Additional comments:		multiple calls to 999 - multi vehicle collision on M4 35-36 West - Tree in carriageway. On arrival liaised with F+R to establish exact circumstances. Numerous vehicles on hard shoulder, numerous persons on hard shoulder, one car on its side into trees. Scene chaotic. Sought senior fire officer. Walked through quickly. established 2 car s involved, one has struck tree and rolled over. Second has struck tree and bounced back onto hard shoulder Both drivers self extricated, walking around at scene Hart resources arrived, and provided a safer drier environment to assess patients. Neither wished to travel to ED despite significant impact. Both drivers restrained, air bags deployed. no intrusion into either driver compartment. Meticulous review did not reveal any injury. Driver one had tachycardia and elevated BP at initial set of observations. This settled. Neither driver wished to travel to ED, both examined very carefully. specific worsening advice given, with low threshold for requesting medical advice and review. it was cold and wet. No available resources. on balance = safer to allow patient to go home with specific worsening advice					

2	SB5854	28/12	54	male	trauma	"Taken a knife to his throat "	no	-	-	yes	yes - EMRTS	nil
				Additional comments:		limited information. clinical description of Pallor ++ On arrival (6 minutes before EMRTS) patient was already being carried on a chair, down the stairs form first floor flat. GCS = E 3 V 4 M 6 = 13/15 Thready radial pulse pressure dressing had been applied circumferentially around neck. x 8 attempts at IV cannulation (4 L, 4 R) Taken into EA laid supine on stretcher. dressing on neck loosened = revealed multiple bilateral stab wounds , no torrential haemorrhage. Clinell wipes used to clean blood from chest and abdomen . This revealed 4 x puncture wounds to epigastrium. 14 G Cannula placed in RIGHT ACF = 500 mg Tranexamic acid given IV (500 mg had already been given IM) A= Airway clear, but expanding haematoma on anterior neck B = Bilateral air entry , surgical emphysema over whole anterior chest C = thready radial D = GCS 13 as stated E = Epigastric wounds only identified after cleaning chest and abdomen. EMRTS attended PHEA to protect airway FAST scan showed ? Haemopericardium 3 x packed cells given LEFT sided thoracostomy assisted transfer to UHW I had offered to undertake Thoracostomy, but was essentially told to stand aside. I am curious as to why only a left sided thoracostomy was undertaken, there was evidence of pericardial collection on FAST scan. Left sided thoracostomy resulted in audible release of air. Wounds were epigastric.						

		Whilst I accept that subsequent scan at UHW did not show RIGHT sided tension, the clinical picture at scene was far less convincing. Manual ventilation resulted in rise and fall of both sides of chest, auscultation was compromised by surgical emphysema over whole of anterior and lateral chest wall. Would anyone have performed bilateral thoracostomies? Plan was for EMRTS to escort to UHW "and pull over to do clamshell if he arrests". . . . . this would perhaps have been easier with bilateral Thoracostomies.

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Governance

Team shift 31/12 – Case 3 and Case 4

Solo Case 2 – EMRTS primarily