Activity Report

Week commencing: 27/09/2021

Team Shift Activity:	number of shifts:	0
	number of taskings:	0
	number of patient involvements:	0
	number of governance procedures:	0

Solo Activity:

active responders: SB 5866, SB 5854, CB 664, CB 5851

number of taskings: 9

number of patient involvements: 6

number of governance procedures: 0

Tasking Types:

trauma	7	*adult*	8
medical	2	*paediatric*	1
cardiac arrest	0		
other	0		

Case	Res	Date	Age	gender	type	Job description	S/D	Scene time	Total time	General interventions	Governance interventions	Adverse events
1	SB5866	27/09	13	male	trauma	Head injury	no	-	-	yes	no	nil
				Additional comments:		Manual SMS: “ANYONE AVAILABLE TO ASSIST AGITATED HEAD INJURY, VOMITING, 13YOM IN XXXX, HE WON'T GET IN TO A VEHICLE. EMRTS COMMITTED. CONTACT XXXX IF AVAILABLE” Hit over head during ice hockey training (helmet worn) now vomited x 6, photophobia, unsteady on feet and parents report left facial droop x 2 episodes. ["IV access"] Arrived. Assessed. No neurology. GCS 14 (E4/V4/M6). Supported RRV decision making. Analgesia & antiemetic. Paramedic escort to UHW in UCS vehicle, pre-alert by myself (Stage 4 of Trauma Tool).						
2	SB5854	29/09	42	male	trauma	Traumatic Cardiac Arrest	no	-	-	yes	no	nil
				Additional comments:		Motorcyclist travelling at a speed estimated to be around 90mph (estimate from crash scene investigator who attended later) had clipped kerb, and lost control of machine. subsequent collision with street furniture/traffic signs CPR ongoing						

						ED consultant and ITU consultant also in attendance along with two medical students (passers by) A = intubated COTT B = Ventilated with Ambu Bag. Bilateral finger Thoracostomies already performed. Marked surgical emphysema C = ongoing chest compressions D = TCA GCS 3 E = right hand essentially detached at wrist, radius and ulna visible, but no active haemorrhage from this site. Blood pouring from Thoracostomies with each compression. probable flail chest/massive chest trauma. Right patella avulsed and distal femoral compound fracture. NOTE: Suggestion for one of the consultants that they should proceed to clamshell thoracotomy was politely challenged. Asystolic arrest with a down time of over 20 minutes Massive chest trauma Surgical emphysema suggested airway disconnect distal to COTT = Ventilation was leaking out and was palpable in the form of surgical emphysema. Discussion surrounding the decision to withhold thoracotomy became quite polarised. EMRTS attended. No blood given on the basis that patient was by this time clinically dead. Confirmed with POCUS. At times we become quite unimpressed by the level of skills we as a team possess. When our hospital colleagues are faced with cases such as this out in the field, it can be challenging. I undertook a hot debrief with one of the consultants which hopefully they found helpful. I spent a bit more time with the medical students thanking them for their help advising them of the need to process their involvement and seek help at a later date if they needed to talk further.						
3	CB664	30/09	48	female	medical	Collapse, Abdo Pain	no	-	-	yes	no	nil
					Additional comments:	06D02 - the patient had undergone insertion of an IUCD a few hours previously and had developed severe abdo pain while at home. She had been seen to collapse from her chair while on a Zoom call with colleagues. Examination and observations. She was fully conscious by the time I arrived with no significant injury and no residual abdo pain. Apart from some bleeding PV as expected, there were no signs of uterine perforation or peritonism. After a period of observation during which she remained well and after contacting her GP it was agreed that she would remain at home in the company of her partner. She was advised to seek urgent medical help if abdo pain returned, if there was significant bleeding PV or if she developed pyrexia or rigors. The patient was also advised to contact the IUCD clinic to seek earlier follow-up.						

4	multiple	30/09	29	male	trauma	RTC Motorcyclist vs Wet Tarmac.	no	-	-	yes	no	nil
				Additional comments:		multiple responders: SB 5866, SB 5854 Initially 29D07 (Unconscious = Red), downgraded to Amber as breathing but not fully alert. Biblically wet drive to scene. On arrival road closed. RPU, DCA + RRV on scene. Patient helmet removed, fully clothed in leathers prone on floor with O2/MILS. No monitoring. Blanket and brollies from MOP. 30 Sec round: <C> Nil A Self (NRBM 02) c MILS, B Chest rising ~28/min, C Radial, D Alert, E RRV paramedic concerned ?Bilateral CLOSED Femur #s Plan: Continue MILS/O2. IV Access, TXA, Fentanyl Cut leathers to rear. Rolled supine onto Scoop/Binder/Blocks>Onto stretcher into blizzard>Load into EA and reassess/treat. ["IV access"] ["Ultrasound (other)","Limb splinting","Immobilisation","Assisted Transfer"] ["Drugs outside JRCALC guidelines (non-governance)"] Fentanyl 500mcg RM arrived, plan conveyed. -18G DRH. -100+150mcg Fent, 1g TXA -Leathers off. -Rolled onto binder/scoop, blocks placed. -Onto stretcher into blizzard>Load into EA Repeat 1y survey: - LUL hand very dusky purple vs RUL, sensation present but subjectively different to other side. - RLL about 5cm shorter than LLL and rotated, R thigh tender +++: For KTD					

						- Pelvic binder adjusted. - 16G LACF - PAR 1g, OND 4mg, Further aliquots Fentanyl - KTD applied and leg length discrepancy resolved. - Logistics of vehicles sorted and left scene for UHW (MTC TT +ve) pre-alert via Trauma Desk (poor signal into UHW but desk [TA] passed complete ATMIST). -eFAST en-route no overt chest injury/PTX/effusion on PLAX, no apparent FF RUQ/LLQ/Pelvis. -Good reception from TT @ UHW [SM]. Good job - only reflection from WAST staff is that they would not have removed clothing given meterological conditions. Rationale RE: Full exposure, missed injuries and removal of wet clothing + expectations of MTC explained. XC2 driven at road speed to UHW by RRV paramedic.						
5	CB664	30/09		male	trauma	29D05 - RTC	yes	-	-	no	no	nil
				Additional comments:		- a vehicle with a single occupant had collided with a wall. A medical event was suspected to be the precipitating cause. Nil - stood down en route						
6	CB664	02/10				29D03 - RTC	yes	-	-	no	no	nil
				Additional comments:		- 2 vehicles between Jcts 43 & 44 Westbound. Nil - nothing found by me or police at given location nor at postcode or W3W address.						
7	CB5851	02/10	50	male	trauma	29D03 -RTC	no	-	-	no	no	nil
				Additional comments:		CAR OUT OF CONTROL FLIPPED INTO HEDGE FIELD Unable to get through to ECCH or trauma desk for any further info self mobilised given local knowledge of fast road with significant cliff drops off towards sea, significant rain and low cloud precluding aircraft access. Arrived on scene to RRV(DOM), EA, police vehicles x 3, no FRS in attendance RTC, single vehicle, loss of control in heavy rain. Though small dry stone wall into field, rolled onto side and self righted. Driver and pax self-extricated. Seat belts worn, airbags deployed, no significant intrusion into passenger compartment. Driver minor injuries only - to Bronglais for wound care (laceration to forearm requiring cleaning +/-closure). Female pax uninjured. Stood down at scene, crew dealing.						

8	SB5866	03/10			medical		yes	-	-	no	no	nil
				Additional comments:		Stood up by ASD as crew request and HM will be delayed lifting. Stood down en-route. In XC2						
9	SB5866	03/10	54	male	trauma	Road cyclist trapped under car.	no	-	-	yes	no	nil
				Additional comments:		After 10mins car raised by MOP using jacks, but still trapped, released by FRS after 30mins. Primary survey, exposure, packaging. Liaison with EMRTS - critical care not required. Analgesia +++ including 1g Paracetamol, 30mg Morphine, 50mg Ketamine total. eFAST (chest) no apparent PTX. ["Ultrasound (other)","Limb splinting","Immobilisation"] ["Drugs outside JRCALC guidelines (non-governance)"] Ketamine 50mg CT Trauma: Bilateral small PTX, multiple bilateral displaced rib # including radiological flail. Dislocated and # right humerus.						

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

No Governance