MEDSERVEWALES

Activity Report

Week commencing: 13th December 2021

Team Shift Activity:	number of shifts:	3
	number of taskings:	11
	number of patient involvements:	9
	number of governance procedures:	2

Team Shift:

Date:	14/12	**Duration:**	09:45	**Personnel:**	MC, TA, TH
No. of taskings	3				
trauma	1	*adult*	3		
medical	2	*paediatric*	0		
cardiac arrest	0				

Pre-shift issues	nil	**Post-shift issues**	Kit wise: Temp probe cable providing intermittent reading. No size 5 iGel's in store. 1 x red bag needs a size5 iGel. (Note in pouch and not tagged) If you take the last item, or notice less than 5 for critical items, please highlight this so that stock can be arranged.
Pre-comments	Shift book-on & checks by TA/TH and MC collected prior to book on. Many thanks!	**Post-comments**	Another successful deployment of the iSTAT. Two busy jobs, second of which will generate a discussion for sure.

Case	Age	gender	type	Job description	S/D	Scene time	Total time	General interventions	Governance interventions	Adverse events
1	33	female	trauma	RTC	no	-	-	yes	no	nil
	Additional comments:			Female driver of Car, low speed clipped stationary car and rolled into roof. Self extricated - Head injury no red flags for CT Lumbar back pain - no midline tenderness Advice re OTC analgesia and safety netted for MIU of red flags						
2	55	female	arrest	OOHCA	no	01:14	02:36	yes	yes	nil
	Additional comments:			- Found collapsed by husband - no initial bystander CPR but crew arrival within 5 minutes. - On WAST arrival asystole - achieved ROSC with 2x adrenaline. - Rearrested on our arrival into room. - Intubated mac 4 DL. G1 view. Bougie, size 8 tube @ 20cm teeth. Confirmed with ausc and CO2. - LUCAS - 2x Re-Arrest, drugs & CPR as per ALS (total further downtime 6 minutes). ROSC. Packaged onto scoop/straps and blocks to extricate downstairs for 360 access in living room. - 2nd IVA LDH 20G - Adrenaline infusion 10mcg/ml at 15ml/hr - Propofol 10mg/ml at 6ml/hr - Temp Probe - Onto Medserve monitor and Vent TV 440ml/IE1:2/RR22 to aim CO2 4-5 - Adrenaline 10mcg/ml. Total 5ml. Transferred onto ambulance. Further 2x arrest further downtime 8 minutes. Drugs/CPR as per ALS. ROSC. ["IV access","Advanced life support","LUCAS"] ["Assisted Transfer"] BP 170/94 (likely artefact during transit) HR 97 Sats unrecordable. EtCO2 6. GCS 3/15. - Propofol stopped. - Vent rate increased to 30						

				- Sodium Bicarbonate 8.4% 100ml - VBG ph6.88, BM 3.5, K 5.6 - 100ml 10% glucose. ["Pre-hospital Sedation"]						
3	52	male	medical	Collapse	no	00:56	02:19	yes	yes	nil
	Additional comments:			Original triaged as Amber-2. DR01 eating lunch in Tredegar Ambulance Station when SMS for RED call received 14:07, called in and not required. Later contacted by EMRTS and asked to attend as closer than Dafen crew. 52yrs male heard shouting for help by neighbours, housing association gained access, found on floor and 999. RRV first on scene found patient with HR~30, unrecordable BP and tachypnoeic. Requested EMRTS, FRS for extrication and EA. On arrival patient laying right side down in between rooms c/o pain in chest and abdo: <C> Nil A/B Self C HR on monitor of 20-30bpm, Complete Heart Block with idioventricular escape rhythm on rhythm strip/12 lead. No recordable BP, no radials. D GCS 14 (E4/V4/M6), BM 9.4, Temp 34.4. E Nil of note. No IV Access - difficult to see any veins. Plan to move into larger room on scoop, gain IV access +/- POCUS, consider ATR & ADX infusion +/- Pacing. Moved on scoop and went into VT, Shocked x 1>PEA. iGel, BVM, 100% O2 and prepared to intubate. CPR by FRS "Give it some welly" LD IO to Right Humerus by TH ADX 1mg 1:10,000 and ATR 1.2mg. ROSC to GCS 14 again. Pacing commenced (fixed) via AP pads at 80-bpm with capture at 100mA but poorly tolerated.						

		Full monitoring including ETCO2 via Tempus. 2 x 100mcg ADX boluses given post arrest in an attempt to >BP/HR. ["IO access","Advanced life support"] ["Assisted Transfer"] Extricated to outside of property on scoop. Onto stretcher with Blizzard/Scoop/Blankets. Given 1mg MDZ and pacing optimised, ADX 10mcg/ml infusion at max rate (33mls/hr) and further ATR 1.8mg [to max total dose 3mg]. Brief ?arrest with HR <20bpm but fought off attempts at CPR. LD IO sited Left Tibia as back up access. Discussion over ?PHEA to gain control but on balance decision for gentle sedation with MDZ given profound haemodynamic instability. Discussion over PCH vs UHW, team decision for UHW given more guarantee over access to PPCI +/- Transvenous pacing as likely to arrive towards end of working day. Loaded into EA and secured. Pre-alert to UHW via ASD. 1550 en-route (having had 2mg MDZ over about 20mins) became Grey, then blue, then <<RR to 6 (Agonal gasps). No palpable pulse. In retrospect, this was most likely a loss of capture +/- deterioration from p-wave asystole to true asystole! EA pulled over within 90secs in place of safety. Decision by MC even though agonally gasping that pacer not generating cardiac output despite electrical capture and so to treat as (peri-)arrest and secure airway. BVM>MAP C> once stopped COETT 8.0, Mac 4 DL, Grade 1, Bougie, 22cm, ETCO2 +ve. Reoxygenation and further 200mcg ADX lead to weakly palpable central pulse and improvement in colour and ETCO2. Once ROSC and tube proven, 3mg MDZ and 50mg Rocuronium given (1555) to aid ventilation and commenced on ventilator 500x20/6 FiO2 0.8. Temp probe sited. Handed over in ED to Consultant, Anaesthetist requested on arrival. Initial VBG: pH 7.16, pCO2 4.78, BE -14.4, Bicarb 12, Hb 144, K+ 8.0, Na+ 132, Glc 1.8 ??? , Lac 9.1 Discussions between ED Cons, MC and Cardiology SpR as apparent while changing equipment over to ED pacer that patient in true ASY as ED Defib wouldn't pace in Demand mode as no p-waves. Cardiology opinion that even with transvenous pacing, patient unlikely to survive. MC noted significant time lapse since presentation and continuing downhill trajectory. ED and Cardiology left to discuss as MEDSERVE cleared ED for end of shift. Follow up: Pacer turned off. RIP. In the interests of probity I am going to flag my tube to discuss at CG [MC].

		Patient was agonally gasping, we couldn't feel a pulse but had electrical capture on the monitor and pt had pinked up with ventilation. Team consideration was that pt was in very low flow/peri-arrest/arrested state. **["Pre-hospital Sedation"]** timing - decision: 15:00, start: 15:00 operators - MC location – outside indication – transcutaneous pacing medications – midazolam (initial 1mg, total 2mg) O2 applied, etCO2 monitoring comments: Peri-arrest **["Transcutaneous Pacing"]** operators: MC, TA, TH prior meds: atropine, adrenaline pad placement: AP initial HR: 30 capture current 120mA set rate: 80 BP stable, mechanical capture complications: Arrested in transit. comments: Would isoprenaline have helped?, 3mg ATR and ADX infusion, what other options do we have?

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

Team Shift:

Date:	17/12	**Duration:**	11:22	**Personnel:**	CW, RL, JK
No. of taskings	4				
trauma	2	*adult*	4		
medical	1	*paediatric*	0		
cardiac arrest	1				

Pre-shift issues	nil	**Post-shift issues**	nil
Pre-comments	?AAcard	**Post-comments**	nil

Case	Age	gender	type	Job description	S/D	Scene time	Total time	General interventions	Governance interventions	Adverse events
1	24	male	medical	SOB	no	-	-	yes	no	nil
	Additional comments:			Known COVID positive self Isolating at home with Mum. Awoke from evening nap feeling SOB. All Obs normal. Advice for self care. Remain at home. Worsening advice given.						
2	36	female	trauma	Fall	no	-	-	no	no	nil
	Additional comments:			Drunken fall in high heels onto railing, 2nxh laceration to forehead extending into hair line. No LOC. Otherwise well. Being taken to hospital by family on our arrival. Advised correct COA after swift assessment of patient conscious level and wound.						
3	21	male	trauma	Pedestrian v car.	no	-	-	yes	no	nil
	Additional comments:			No LOC. No neck pain. 10/10 pain left upper leg. Multiple abrasions to hands, arms, left side of face, laceration to left ear separating upper pinna from scalp by 15mm. ["IV access"] ["Limb splinting","Assisted Transfer"] 1ry survey Dx # left femur. KTD applied. Accompany in ambulance to Heath MTC. Fentanyl 150mcg, Paracetamol 1g, TXA 1g, ondansetron 4mg Difficult extrication as trolley would not fit through pub doors. Placed on scoop and vac mat to allow lifting vertically to move through doors.						
4	55	female	arrest	Cardiac arrest.	yes	-	-	no	no	nil
	Additional comments:			CPR in progress. Announced conscious and breathing whilst en-route. Two ambulances in attendance. Stood down.						

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Team Shift:

Date:	19/12	**Duration:**	09:00	**Personnel:**	IB, CJM, JR
No. of taskings	4				
trauma	1	*adult*	4		
medical	1	*paediatric*	0		
cardiac arrest	2				

Pre-shift issues	nil	**Post-shift issues**	Digi-pen ink running low - no obviously apparent replacement available. Fuel below 3/4 - not refuelled due to finish time from last tasking - IB working following day. IB will refuel car.
Pre-comments	JR first shift	**Post-comments**	JR first shift - thoroughly enjoyed.

Case	Age	gender	type	Job description	S/D	Scene time	Total time	General interventions	Governance interventions	Adverse events
1		male	trauma	Hit by train	no	-	-	no	no	nil
		Additional comments:		traumatic cardiac arrest Massive head injury incompatible with life Alloc 16:15, Scene 16:22						
2	49	male	arrest	Cardiac Arrest	no	-	-	yes	no	nil
		Additional comments:		Known CCF, awaiting AVR, In bed unwell last few days Collapse after climbing stairs AED applied, 5 shocks, EMS arrival VF, further shock into asystole. ["IV access","Advanced life support","LUCAS"] ["Ultrasound (cardiac)"] Lucas, uss, Role Alloc 17:52, Scene 18:10						
3	78	male	arrest	Cardiac Arrest	yes	-	-	no	no	nil
		Additional comments:		Alloc: 21:02, Mob: 21:02, S/D: 21:11 ROLE by WAST pre-arrival.						

4	72	male	medical	c/o haematemesis, collapsed in bathroom	no	-	-	yes	no	nil
	Additional comments:			Off duty EMT on scene advising pt peri-arrest. O/A - Paramedic EA crew at scene. <C> - Nil A - Patent B - Tachypnoeic, unrecordable SpO2, 100% OXG in situ via NRB C - Tachycardic, unrecordable BP, no radial pulses, pale++, mottled, diaphoretic, IV access x2 14G by WAST. 1g TXA by WAST Para (?Halt-It). Sodium chloride infusion (slowly trickling rather than bolus). D - GCS E3 V5 M6 = 14 ["Assisted Transfer"] Assisted WAST with pt movement and extrication. IB contacted PCHM via North Gwent desk to Pre-alert and activate major haemorrhage protocol. CJM and JR escorted pt on EA during transport. Nil change in pt condition intra-conveyance.					

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Solo Activity:

active responders: CB 5851, SB 5866, SB 5854

number of taskings: 4

number of patient involvements: 4

number of governance procedures: 0

Tasking Types:

trauma	2	*adult*	4
medical	0	*paediatric*	0
cardiac arrest	2		
other	0		

Case	Res	Date	Age	gender	type	Job description	S/D	Scene time	Total time	General interventions	Governance interventions	Adverse events
1	CB5851	13/12	84	male	arrest	Cardiac Arrest	no	-	-	yes	no	nil
				Additional comments:		witnessed deliberate entry into river in Carmarthen town centre. Rapid rescue by FRS, in cardiac arrest. Immediate BLS from FRS. ["IO access","Advanced life support"] On CB5851 arrival, CPR ongoing. Brief update to ECCH. Tasked EMS to dry chest and get defib pads on --> asystole. Intubated by 5851, grade I, bougie, 8.0 COETT, 24cm at lips. Tasked EMS to obtain tibial IO access --> adrenaline ALS ongoing, D/W MCGA ground team, stood down R187, EMRTS arrival as preparing further update ROSC then in-and-out of VF, decision to transfer to Morriston for extracorporeal warming given core temp 28c					
2	multiple	15/12		male	trauma	Single vehicle RTC	no	-	-	yes	no	nil
				Additional comments:		multiple responders: SB 5866, SB 5854 **MC:** “2 patients both unconscious” FPOS, road blocked with SB 5866 vehicle. Driver (Male 20’s): Agitated and screaming.						

		Passenger (Female, 20's): Slumped forward, breathing but unresponsive. Driver and passenger appear intoxicated, driver ?distracted by passenger. Passenger dragged out onto roadway. A: Clear. B: Rapid/shallow. C: Radial pulse. D: Smells of ETOH, 6mm sluggish pupils, GCS E2/V2/M3 E: Patted down, nil of note. Monitoring applied, SpO2 87% so NRBM O2 Patient 2 agitated, being reassured by public. Updates to control as multiple resources arrived simultaneously (EA, RRV, SB 5854, EMRTS) Passenger scooped, into EA, pre-alerted UHW. Driver intoxicated and agitated. ?open jaw # so given IV Abx by RM. ["IV access"] ["Drugs outside JRCALC guidelines (non-governance)"] Co-Amoxiclav 1.2g Remained obs stable. 2nd EA after ~1hr, pre-alerted UHW. RM: Driver of car, not wearing seatbelt. Initial review showed his clothing to be loosened and deranged, in a way that suggested the dishevelment was pre collision. Female passenger may not have been secure in her seat either. Clinical behaviour suggested intoxication. Car had driven into a solid stone wall at 30 mph Patient initially thought to be unconscious, but woke up by the time I arrived ABCD = acceptable laceration to chin clinical suspicion of Fracture to LEFT angle of mandible. C spine cleared

						assisted from vehicle. laid on scoop and kept warm Co-Amoxiclav IV for presumed compound fracture of jaw. ATMIST to UHW						
3	SB5866	18/12	20	male	arrest	Cardiac Arrest.	no	-	-	yes	no	nil
				Additional comments:		Alerted by GoodSAM, no radio but Defib & Kit in car. Responded at road speed (300m). Gated complex, parked outside and jumped fence. ROLE Parking enforcement for parking in residents only zone. QC1734539A - will appeal. Desk contacted and requested to retrospectively add to tasking with arrival time as per RRV of ~1035hrs.						
4	SB5854	19/12	24	male	trauma	Motorcyclist v car	no	-	-	yes	no	nil
				Additional comments:		patient trapped under car - initially thought to be TCA. On arrival HART on scene patient supine on a backboard ABC clear D = GCS 14 E4 V4 M6 E = compound nasal fracture Possible Pelvic fracture Comminuted Mid shaft LEFT femur ["Limb splinting","Immobilisation","Assisted Transfer"] Fentanyl 90mcg, Ketamine 20 mg Pelvic Binder advised. Warming advised (Blizzard + Heat pads) Analgesia FENTANYL 90 MCG KETAMINE 20 MG Good effect LEFT left splinted with KENDRICK (Dorsalis Pedis present throughout on the LEFT foot) Immobilised						

		ATMIST to UHW (Trauma Desk unmanned so direct ATMIST to UHW) Deep lacerations to the LEFT patella - does this make the LEFT femoral fracture compound? should I have given Co-Amoxiclav at scene? I assume that the trauma desk/EMRTS desk was unmanned, because none of us has a 12 hour bladder capacity!!!

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Governance

Team shift 14/12 – Case 2 and Case 3