Activity Report

Week commencing: 20th September 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: CB 664, SB 5866, SB 5854, SB 5858

number of taskings: 7

number of patient involvements: 7

number of governance procedures: 0

Tasking Types:

trauma	6	*adult*	6
medical	1	*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	CB664	20/09	48	male	trauma	30D05 – leg injury	no	-	-	yes	no	nil
				Additional comments:		the casualty had attempted to stop a 3x2m slab of granite (~200Kg) from falling. He had suffered forced extension/lateral flexion of the R knee and complained also of pain in his R heel. Examination and observations. Analgesia. Penthrox 3.0mls ["IV access"] Liaison with H57 who also attended. Casualty conveyed to hospital by work colleague given likely extended delay before EA available.						
2	multiple	22/09	74	female	medical	Unresponsive – near drowning	no	-	-	yes	no	nil
				Additional comments:		multiple responders: SB 5866 and SB 5854 Pulled unresponsive from pool, initially agonal breathing. Newport area. Advised en-route that HM65 making scene, elected to continue as congested landing zone. Arrived 2mins after GWAAC. Pt found to be ABC ok but D wise E2/V2/M5 at best. 12 lead ECG unremarkable, BM normal. PERLA with no apparent limb weakness or gaze deficits. D/w GWAAC team and suggested conveyance options are GUH vs UHW but given events and suspicion over potential for ICH, pts best interest served by going to UHW (Neurosurgery +/- Stroke Thrombectomy as there is a Neuro-Embo list on Wednesdays).						

						Agreed no acute need to RSI, even with relatively low GCS as with pt sat up no airway compromise. MC/RM happy to transfer and free up GWACC team to return to SWAST. Uneventful transfer to UHW, OND en-route. ["Assisted Transfer"] CT Angio: Diffuse SAH in sulci of both hemispheres. Blood in basal cisterns. Early Acute hydrocephalus. Multiple Intercranial aneurysms (2 Left MCA, 1 Right P-COMM). Should we have given TXA?						
3	CB664	22/09		male	trauma	27D03S	no	-	-	yes	no	nil
					Additional comments:	- the casualty had been assaulted with a bladed article. It was initially reported that he was bleeding profusely from both head and neck wounds. I received a stand down message just as I arrived on scene. Liaison with WAST personnel dealing. Head wound only - bandaged and no ongoing bleeding Assistance given with cannulation. The casualty was conveyed to Morriston without my needing to escort him.						
4	CB664	23/09	7	male	trauma	29D02M – pedestrian vs car	no	-	-	yes	no	nil
					Additional comments:	- the casualty had run out in front of a small SUV on a minor residential street. He had not been knocked out and had wanted immediately to try and get up but was restrained by his mother. Assessment and analgesia (calpol PO and fentanyl intranasal) - Fentanyl 37.5mcg IN Assistance with transfer to EA. Conveyed to Morriston after discussion with Trauma Desk.						
5	SB5854	23/09			trauma	RTC	no	-	-	yes	no	nil
					Additional comments:	A472 = 60 mph limit. Car ONE drifted across central double whites, causing head on collision, passenger compartment -> passenger compartment. Car TWO = Police Vehicle, driven at road speed. Driver and Passenger = PCSOs Both cars spun around to face opposite direction of original travel. Massive intrusion to both passenger compartments. On arrival, WAST resources present and arriving. Police and FRS at scene						

		Car ONE : Driver = Elderly male (70s) GCS 15. No immediate concerns regarding airway or haemorrhage. Passenger = Elderly female, GCS = E1 V2 M1 = 4 Pallor ++ = White ! Chin on chest, grunting. Advised MILS and Jaw thrust to clear airway. Time critical extrication agreed, care handed over to Paramedics/APP. Car TWO: Driver = Female PCSO (30s) GCS 15, no immediate concerns with haemorrhage or airway Passenger = Female PCSO aged 27 Initial GCS = 3, thready radial pulse Trapped mechanically by intrusion of engine block and A post into passenger compartment. Agreed with FRS = immediate extrication = Time critical. A post rammed to create more space. assessment of legs showed compound Tib and Fib RIGHT leg, closed ankle fracture LEFT side, but both legs could be freed to allow extrication. Moving legs caused patient to scream = GCS improved E2 V3 M5 =10 Cannulated RACF 16G (paramedic) Ketamine titrated to response = 50 mg TXA and Ondansetron given, Assisted extrication using spinal board to stretcher. Scooped, Pelvic binder applied. Airway clear, Breathing R=L = bilateral air entry, sats 98% on air, Circulation = Pulse 98, BP 111/62, CRT = <2 D = GCS E2 V4 M5 = 11 following Ketamine. Pupils Equal and reactive, Complains of no sensation in legs E = C spine MILS because of mechanism, airway patent Injuries: Chest clear; Abdomen = RIGHT hypochondrial contusion, abdomen tense; Degloving injury to LEFT elbow; Mid shaft LEFT femur #; LEFT ankle # , crush injury and compound # LEFT Foot; Right Compound Tib and Fib #; Facial bruising/Periorbital bruising on the LEFT ["Limb splinting","Immobilisation","Assisted Transfer"] Ketamine 50mg Pelvic Binder already in situ Kendrick Splint to LEFT Mid shaft femur = good result, leg lengths equal (Applied OVER pelvic Binder) All wounds dressed appropriately, Co-Amoxiclav1.2 g Secured to scoop. Head blocks and tape, NO collar

						ATMIST passed directly, not Via trauma desk. Police escort x 4 motorcycles to UHW. en-route BP dropped = systolic 80. patient still talking. UHW contacted to establish Major Haemorrhage protocol activated. Repeated BP = systolic 130 . . ? 80 = spurious reading. Handed over alive at UHW. NOTE: Passenger in Car ONE went into TCA whilst I was assisting extrication of Female passenger from Car TWO . HOTT management by APP and colleagues. Active decision to stay with younger salvageable patient than be distracted by TCA . Patient ROLED at 25 minutes . I assume catastrophic internal haemorrhage. Good teamwork WAST /Medserve/ FRS/Police Appropriate use of my time in concentrating on salvageable younger patient. HOTT management by APP etc = by the book . All I could potentially offer was bilateral Finger Thoracostomies which would have been time consuming diversion and "Window Dressing".						
6	multiple	24/09		male	trauma	assault – ankle injury	no	-	-	yes	no	nil
					Additional comments:	multiple responders: SB5866 and SB5854 History of patient having twisted ankle, but further enquiry at scene revealed assault. Facial bruising and contusion, Not knocked out Main concern was open dislocation of the LEFT ankle Patient admitted to being a recovered IVDU with difficult access. Haemodynamically stable throughout Pulses present in injured foot. ["IV access"] ["Limb splinting","Immobilisation"] Cannulated 22G Blue (MC) Morphine and Entonox given as analgesia Co-Amoxiclav given 1.2 g IV attempt 1 to reduce dislocation (RM) unsuccessful Attempt 2 = MC = partial reduction. dressed and splinted. ATMIST to GUH						

						Discussion regarding use of Ketamine and formal procedural sedation . Proximity to definitive care suggested transfer more appropriate						
7	multiple	26/09	20	male	trauma	Quad bike vs motorbike	no	-	-	yes	no	nil
					Additional comments:	multiple responders: SB 5858 and SB 5854 Reported as 2 person, quad vs motorcycle at 40 mph. One pt GCS 3. On arrival 12 yr old on quad awake/ talking with arm injury in EA with UCS - eyeballed -looked ok Directed to male down bank- thrown from bike. Had been unconscious but spat out Oropharyngeal airway that UCS had inserted and was verbalising ["IV access"] ["Immobilisation","Assisted Transfer"] ["Drugs outside JRCALC guidelines (non-governance)"] Paracetamol 1g TXA 1G A -own B- equal chest expansion, normal breath sounds , no pain, could deep breath C- Pulses all four limbs HR 95. BP 114/70 D- bit repetitive, *Dizzy" PEARL3 E - abrasions to both thighs, pain in pelvis and femurs , rt looked more swollen but Lt more painful. Abdo soft Toc- 1425 allocated and mob 1458 At scene 1514. Backed up by RM and Bristol Helimed team. Slow to leave scene ,as 12 yr old was in EA. UCS can't drive on lights. I did not want to leave 12 yr old with UCS on side of road with many people milling around, filming etc. In end I travelled with two patients and UCS in 1 EA. RM reviewed 12 year old male (Quad Bike), main concern was painful shoulders. Full range of movement, albeit painful. C spine cleared. Haemodynamically stable Conveyed to UHW (Age + Mechanism)						

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

No Governance