



# HCTA Newsletter

Volume 3 Issue 2

July 2000

## ***Three Souls on Board Returning Home Dedicated to Alicia, Mark and Erik***

*Diane F. Fojt, President, MECA, Inc., Vice President,  
CISM of Florida, Executive Director, Tampa Bay  
Regional Critical Incident Team*

April 25, 2000 holds a special and tragic place in my heart. For that was the day we as an emergency service family lost three very dedicated and wonderful individuals to a tragic accident. For many, the questions linger on. What could have happened in the cockpit that fateful day to cause them to run into wires supporting a radio tower? Could there have been some reason other than pilot error? Was there a distraction, a flock of birds? The questions run on and on. The fact is, we may never get our answers. We are left with the difficult task of trying to understand something that we do not want to accept. We are in the business of responding to chaos and horrifying events but nothing in life can prepare us to react any differently when it's our tragedy. Something I talk about in many lectures that I give is that as health care providers we need to be cognizant of our patients and their families emotions and that it is OK to feel another's pain and to be human. Every day that we go to work, we experience trauma and sometimes loss through others, but what have we learned from this? What is this tragedy trying to teach us?

In all my experiences with the critical incident stress work that I do, I have seen and heard an enormous amount of pain and suffering from those of you out there on the front lines. The most difficult situation we can come across in our career is a line of duty death. They are by far the most difficult debriefings to do and unfortunately I have done many in my seventeen years of CISM work. This time the phone rang to bring the message of a downed aircraft, possibly Bayflite 3.

This time it hit ground zero. Bayflite was the first flight program I'd ever worked for and this was very personal. Everything runs through your mind at a hundred miles an hour. Then I received the next blow, the names of the crew members. It felt like someone had sucked all the air out of me. At the same time there was a job to do. With the help of many, CISM teams were quickly organized and dispatched to the three hospitals to begin the long process of stabilizing and healing.

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The healing will take years for the family and friends of the crew. Life as we knew it had been changed forever without our consent. We didn't even get a chance to try to save them and that is very hard to accept. So back to my question; what have we learned about life and about death? What this has taught me is the very thing that often I have tried to teach others. Life is precious. You get one ticket on the roller coaster ride of life. There are no guarantees and no one needs our consent when it is our time to leave this world. We have this moment and that's all you can be sure of.

During the days that followed I saw people hugging coworkers and saw former flight crew members who have moved on come back to share the sadness. I saw kindness and compassion towards family members that were strangers before this incident. I saw men crying in public without a second thought. I saw strangers come to the memorial service that didn't even know the crew. I saw the absolute best in humanity and maybe that was the crew's final mission. Let us never forget them and what they taught us.

### ***Thanks to the Community***

*Roxanne Sams, MSN, ARNP, MA, Director, Bayflite*

On Tuesday, April 25, 2000, Bayflite lost three dedicated and exemplary crew members. The depth of our sorrow is profound and immeasurable. The entire flight crew and management staff of Bayflite will be indebted forever to the crew of Aeromed for their support during our difficult times. Kirk Blaske RN and Eddie Stoltz, EMT-P, are heroes for their brave attempt to find and save our crew members. We also would like to extend our thanks to the EMS community that gave us their support and many gestures of sympathy. We felt the hearts and hands of this community surround us in our darkest hours of grief, comforting the crew and all of the family members. Words cannot express the solace we felt

by being remembered with so many kind gestures, flowers, phone calls and attendance at the funerals and memorial services.

### ***Hillsborough County Fire Rescue Implementing RSI***

*David Travis, EMT-P, Quality Management Chief,  
Hillsborough County Fire Rescue*

Hillsborough County Fire Rescue (HCFR) is now performing rapid sequence induction (RSI) for adult trauma patients. RSI involves the administration of sedative and paralytic drugs to facilitate intubation. Candidates for RSI will be those patients who have a likelihood of early airway compromise or who are combative to the point of threatening their airway, spinal cord, or transport safety. HCFR's RSI protocol includes Fentanyl for sedation, and Succinylcholine and Vecuronium as paralytic drugs. RSI may be indicated in some non-trauma patients as well. Initially, the paralytics will be used only on adult patients.

Prior to field implementation of these procedures, HCFR paramedics were extensively inserviced. Their training included lectures by Dr. Charles Sand and a skills lab with an advanced airway component. Their RSI protocol mandates that two paramedics be present to administer this therapy.

HCFR has had a delay in implementing RSI due to the situation that Succinylcholine is no longer available in powdered form and requires refrigeration. Refrigerators have been ordered and should be arriving shortly. As soon as the units are installed in the trucks, RSI will be implemented.

**ATTENTION NURSES AND NURSING ASSISTANTS, DON'T WAIT UNTIL THE «««PERFECT STORM»»» TO TAKE ACTION !**



If you are interested in helping out during an evacuation when Hillsborough County's special needs residents in flood-prone and low-lying areas are forced to leave their homes for the safety of a shelter, you can now receive compensation for your altruism. However, you should plan ahead and you'll definitely want to read this next article that explains the steps you have to go through to get registered.

In case you're wondering what a special needs person is, it's any individual whose medical condition requires more care than a Red Cross shelter can provide but who doesn't need to be hospitalized.

***Healthcare Workers Needed to Staff  
Emergency Shelters***

*Peter Dabrowski, Emergency Planner, Hillsborough County Emergency Management, EOC*

In August, we dodged another bullet when Hurricane Debby turned south and fizzled out over Cuba. Had the storm affected the Tampa Bay area, we could have been in trouble. We barely had enough medical volunteers to open two special needs shelters. Had Debby grown to a Category 3 hurricane and threatened this County, we would have been required to open five shelters, and we simply did not have the workforce to do this.

We need help in spreading the word. Could you please support our efforts to recruit nurses to staff these shelters by signing up and/or telling a colleague or coworker about this new program. For the first time, Hillsborough County is now able to pay RNs, LPNs, and CNAs who work at these Special Need Shelters as temporary emergency workers. He/she will be covered by County liability insurance and workers' compensation. The hiring process is simple. We only require completion of a two page form and a copy of a current license. More detail is listed below. Dialysis technicians are also needed to help staff the dialysis shelter.

Again, I would really appreciate your support. We cannot operate the special needs shelters without staff and we may not be so lucky when the next hurricane comes along.

**ELIGIBILITY:**

Any RN, LPN or CNA with an active Florida license is eligible.

**TYPE OF EMPLOYMENT:**

Temporary emergency hire

**WAGES:**

RN: \$18/hour, LPN: \$12/hour, CNA: \$8.00/hour

**OVERTIME:**

Time-and-a-half will be paid for any time worked over 40 hours in a calendar week.

**'ON-CALL' PAY:**

An additional hour of pay (consider it a bonus) will be given for each day that the RN, LPN and CNA works. A shift consists of 12 hours on and 12 hours off. So anyone that works 12 hours, gets paid for 13 automatically.

**CNA STATUS:**

There is no position in the County Civil Service for a

Certified Nursing Assistant. CNAs will be hired as temporary emergency Adult Day Care Aides at \$ 8.00 per hour.

**INSURANCE:**

All emergency hires will be covered by county liability insurance and county workers' compensation rules.

**SHELTER ASSIGNMENTS:**

There are five special need shelter locations around the county, one or more of which may be opened during an evacuation. Every attempt will be made to pair an individual with his/her shelter preference. The names and addresses of the Hillsborough County shelter sites are as follows:

- \*\*\*\*\*
- Caminiti Exceptional Center, 2600 W. Humphrey St., Tampa
- E. Bay High School, 7710 Big Bend Rd., Gibsonton
- Erwin Technical Center, 2010 E. Hillsborough Ave., Tampa
- Lopez Elementary School, 200 N. Kingsway, Seffner
- USF Gymnasium, 4202 E. Fowler Ave., Tampa
- \*\*\*\*\*

Interested nurses and CNAs can apply by completing a Hillsborough County Application for Employment and the Special Needs Volunteer Form. Send completed applications to:

Hillsborough County Emergency Management  
ATTN: Peter Dabrowski  
2711 E. Hanna Avenue  
Tampa FL 33610

Applications will be screened and those approved will be kept on file. Individuals whose applications are approved will be contacted and their names placed in a staff registry. They will be called prior to shelter activation. One's employment will be activated when the nurse or CNA signs in at his/her designated shelter. Applicants can choose the shelter in which

they desire to serve and are welcome to have family members accompany them. If you have any questions, please call Pete Dabrowski at 272-6900.

***Dr. Edward J. Straub (1940-2000)***

*David Travis, EMT-P, Quality Management Chief, Hillsborough County Fire Rescue*

Dr. Ed Straub was involved in EMS medical direction for 28 years. He was the medical director for the Tampa Fire Department from 1972 to 1977. He became the medical director for Hillsborough County Emergency Medical Services in 1977 and continued to serve in that position after the consolidation of rescue and fire operations into Hillsborough County Fire Rescue. Dr. Straub was a pioneer in prehospital care and both a patient and paramedic advocate since the early days of EMS. He selflessly devoted countless hours to the providers of these services. He was a proponent of new and aggressive treatment modalities and training programs.

Unfortunately, Dr. Straub passed away on May 8, 2000, after a courageous struggle against pancreatic cancer. His personal support, dedication, and sacrifice will be remembered and sorely missed.

***Children Riding as Passengers in Pick-up Truck Cargo Beds***

David Summers, Pediatric Trauma Nurse Coordinator at St. Mary's Medical Center in W. Palm Beach, asks for all of our cooperation in tracking trauma patients who were passengers thrown from the open cargo area of the back of pick-up trucks. The reason: they need to collect stats after their attempt to secure



legislation in the 2000 session that would ban riders from the non-passenger areas of such vehicles was thwarted. Each year more than 200 people die as a result of riding in such areas. More than half of these deaths are children and teenagers.

The trauma community was very disappointed that their efforts were unsuccessful this year but plans to try again next year. They need patient injury data to support the claim that the cargo area of a pickup truck, with or without a canopy, is a source of injuries and death to children and adults. A number of states already have laws or restrictions on carrying passengers in the cargo area of the pickup truck. In addition to the possibility of being ejected, passengers riding in the covered cargo beds are exposed to carbon monoxide from exhaust fumes.

Ejection from the cargo area during a collision was the major cause of injury and death for pickup passengers. Most non-collision deaths were caused by falls due to swerving, braking or rough roads. In a third of these cases, the victim was standing up, sitting on the tailgate or horsing around.

Please submit your facility's information on these injuries or deaths to the Trauma Agency and it will be forwarded to David Summer. Let's all pitch in and work towards this common goal. Prehospital folks: this is not just an ED personnel request. Your input would be most appreciated. If you bring in such a patient, don't automatically assume that the ED staff will report it. Better to call it in twice, than have a case go unreported.

### ***Who's New?***

We want to welcome the new Director of Emergency Services at Brandon Regional Hospital who started in June. Katherine Haddix-Hill, RN, MSN fills the position vacated by Cynthia Hayes, RN. Kathy

comes to Brandon with extensive background in emergency nursing and management, most recently holding the position of Director of Emergency/Trauma Services at Riverside Regional Medical Center in Newport News, Virginia. Her previous experience in the Tampa Bay area includes serving as the Director of the Emergency Center at All Children's Hospital as well as Emergency Department Management Consultant with Higman HealthCare. Ms. Haddix-Hill will be responsible for managing the adult, pediatric and urgent care emergency services at Brandon Regional Hospital. She earned her Bachelor of Science in Nursing at Davis & Elkins College and her Masters of Science in Nursing Administration at George Mason University. In addition, she serves as an Army Nurse Instructor in the U.S. Army Reserve Nursing Corps where she holds the rank of Major.

Nancy Perry, RN, BSN, initially joined the management team of the Emergency Department at University Community Hospital-Fletcher in November 1999 as the Performance Improvement Coordinator. She managed the clinical operations involved with utilization review, quality assurance and improvement process. Now she has stepped into the role of Interim Clinical Care Coordinator. She has been with the hospital for almost two years. Previously she worked at Tampa General in the areas of emergency, trauma, digestive disorders, general surgery, and orthopedic surgery. Nancy came to nursing after a seventeen-year career with the Broward County Sheriff's Office, Fort Lauderdale, as an Organized Crime Analyst. Nancy tells us that her employer is currently conducting a national search for a ED Director.

Sue Neil, RN, is the Interim Director of the Emergency Department at Memorial Hospital of Tampa. Helen Di Vito, the previous ED Nursing Director accepted the appointment of Interim Chief Nursing Officer in the same institution. Sue obtained her nursing degree from Florida State University. She began her career at Tallahassee Memorial Hospital.

From there she went on to Mt. Sinai Hospital in Miami Beach where she became manager of the cardiac surgery and surgical intensive care units. Prior to this appointment, Sue has worked as staff nurse and manager of the ICU, PCU and ED at Memorial during the past 16 years. She also has been an ACLS instructor and taught multiple classes for the hospital.

Graham Roberts, RN, became the Interim Director of Emergency Services at South Bay Hospital after Janie Ratcliffe retired in March. Graham is originally from England, a fact that won't escape your attention as soon as he opens his mouth. He has one of those British accents that we Americans find so charming. Graham received his nursing education back home, graduating in 1986. He worked in a busy London ED for two years before emigrating to Little Rock, Arkansas in 1988. There he picked up experience in general med/surg, oncology, MICU and home health nursing. He moved to Florida four years ago and began to work at South Bay Hospital. Over the years he migrated to the ED, first as a staff nurse, soon after becoming a charge nurse and well, you know the rest of the story. Graham finds the responsibility to be an enjoyable challenge.

### ***Promotions/Advancements***

Holly Boggs, EMT-P, was promoted to the position of Assistant Rescue Chief of Tampa Fire Rescue in April. Holly was one of the first two women hired by Tampa Fire back in 1978. She became a paramedic in 1980. Of her almost 22 years with the department, thirteen were spent on the streets as a paramedic. She moved from the field to Tampa Fire's Skills Lab where she was the Coordinator for 5½ years. While in charge, she introduced PHTLS to the Bay area along with B. Barnett. They put on numerous provider and instructor courses and developed a reputation for having the best classes, drawing students from surrounding areas. She was also

instrumental in bringing Critical Incident Stress Debriefing to Tampa Fire, which later evolved to become the regional CISM team. Most recently, Holly had been the Quality Management Officer for the past three years.

### ***New arrival***

Keith "Chapie" Chapman, EMT-P, EMS Supervisor of Temple Terrace Fire Department, and his wife, Charity, are the proud new parents of Brian Tucker, born June 7th at 7 lbs, 7 oz and 20 ½ in. Chapie had the thrill of his life when the obstetrical staff allowed him to deliver his own son at University Community Hospital.



### ***May Trauma Symposium***

A gangbuster attendance at the fourth annual Trauma Agency seminar broke all previous seminars' records. The event drew 171 attendees (85 paramedics / EMTs, 65 RNs and 21 RTs). Presumably, even more would have attended (there had been 255 pre-registrants) if not for some unfortunate timing. Many called to cancel because of the conflict with Dr. Straub's funeral held that same morning.

Evaluation respondents described the symposium as "excellent" or "outstanding", "great" or "well organized". There were many requests to keep offering this program at least annually, to extend the program to a full day and to include slides of traumatic injuries. Also, quite a number of participants expressed the desire to have a hard copy of the text of the speakers' slides to supplement their notes and to share with colleagues. I am happy to be able to oblige those who are interested. Copies of the Power Point

printouts for four of the five lecturers will be available upon request.

The videotape of the symposium is still in the cutting room being edited. As soon as Gordon Silver, our master videographer of Silver Productions, and Chief Radio Dispatcher of HCEDO, finishes with his work of art, the finished product will be whisked off to make copies. There may be a modest fee to defray reproduction costs, more will be known later. For those who didn't hear, Gordon just won first place in a prestigious national competition for his work. Congratulations!

Planning for next year's symposium is already underway. Once again, it will be held at HCC and we hope to be offering CMEs for physicians as well. We probably will be using a survey to identify topics to satisfy the more rigorous "needs assessment" requirement that physicians' continuing education credit demands, so if you are asked to complete such a questionnaire, please oblige us by responding when polled.

### ***New Focus of Continuing Education at Hillsborough Community College***

*Cathy Moloney, Continuing Education Coordinator, Allied Health and Nursing Programs*

The goal of the Hillsborough Community College Office of Continuing Education is to better serve the educational needs of allied health and nursing professionals in the Tampa Bay area. To further those aims, the Office now has a new dean, Dr. Sharon Miller, and a new coordinator over the Allied Health/Nursing Programs, Cathy Moloney, M.A. (Gerontology). With this change in leadership came a change in vision for the future direction of the department.

Since starting in March, Ms. Moloney has become

very involved in assessing the educational needs of the healthcare community. She has established a nursing advisory council to solicit local input and is working on building partnerships with area businesses and educational institutions to appropriately target her efforts towards specific demands for courses while expanding the program.

As a result of these liaisons, the Office of Continuing Education's emphasis for 2000-01 will be to provide the community with the needed CPR and instructor training classes, be a source for the required AIDS and domestic violence relicensure training, offer Spanish for healthcare workers, and add at least eight new nursing topics to the existing schedule. Plans are in the works to hold one-day seminar/workshops as well as to co-sponsor two nursing related conferences. For the year 2001-02, Continuing Education plans to expand its current allied health courses to include rehabilitative therapies and mental health.

Hillsborough Community College strives to be your community's premiere continuing education center. For more information, please contact Cathy Moloney, Continuing Education Coordinator for Allied Health/Nursing Programs, at 253-7985.

### ***Trauma Triage Criteria Pocket Guides***

Now that everyone has had a chance to use the plastic pocket guides imprinted with the triage criteria, you must have formed some opinions about what you do and don't like about them. One such comment filtered back to me. For example, despite the fact that the adult and pediatric sides are different colors, and the applicable age group is stated at the top on each side, some feel that the words "adult" and "pediatric" still should be squeezed in somewhere. What do you think about that or anything else about them? Phone, fax or e-mail me your opinions. These cards are

going to be reprinted whenever the State revises the criteria (a change in the Florida Administrative Code is expected soon) and/or whenever we modify our own local parameters, as may be decided by the Trauma Audit Committee, so there is a real opportunity to change something you'd like to see different. Additional cards are available for the asking from the Trauma Agency.

**PROVIDERS ARE ENCOURAGED TO SUBMIT CLINICAL ARTICLES FOR CONSIDERATION. PLEASE SHARE YOUR INTERESTING, CHALLENGING, ILLUMINATING, AND/OR GRATIFYING EXPERIENCES WITH THE READERS. THIS NEXT PIECE IS ONE SUCH GUEST ARTICLE.**

### *Do the injuries fit the scene?*

*Lauren Stewart, ARNP, Trauma Nurse Coordinator, St. Joseph's Hospital*

Recently, our trauma center received a trauma alert from out of county which was noteworthy. Apparently, the 81-year-old woman was found on the floor of her room in an ALF. Her eyes were open, she was moving her left side spontaneously, but she would not speak. The EMS crew trauma alerted the patient due to decreased GCS and called for a helicopter.

On arrival, Bayflite performed a detailed assessment of the patient. They found her alert and able to follow some commands with her left side. She was aphasic and her right side was noticeably weak. The flight crew radioed in and advised us that this was likely a stroke patient.

As per protocol, the entire trauma team was mobilized at St. Joseph's Hospital, putting both CT and OR on hold. The trauma surgeon met the patient on arrival to the ED and after a quick examination, canceled the

trauma alert, thereby releasing the CT and OR teams.

The take-home message here lies in the value of a thorough patient assessment. If there is no evidence of traumatic injury, entertain the idea of a medical cause. In this case, a more detailed exam by the aeromedical team revealed classic stroke findings. Patients with a traumatic brain injury are usually combative, confused, often with eyes closed or widely open. The patients will not likely follow commands, and if they do, most of the time, the movement is symmetrical. The appearance of the pupils imparts additional information as well. For example, asymmetrical, deviated pupils are usually associated with an intracranial hemorrhage.

Additionally, blunt trauma will rarely produce aphasia, unless the patient is completely comatose. Aphasia is a classic sign of CVA, but not trauma. Perhaps an isolated penetrating injury may produce aphasia, but in those situations, there undoubtedly would be an entrance wound or object protruding from the skull.

It's difficult to tell in the field whether the patient's condition is due to a medical or traumatic event. However, look at the entire situation. Are there any marks of trauma on the patient? Consider carefully all potential causes. You would definitely want to transport the patient to the nearest trauma center. However, keep the causation and patient presentation in mind when activating a trauma alert. Trauma teams should only be mobilized when there is a strong suspicion of trauma to make the best use of those resources and assure their availability when they're really needed. If you're still not sure of the causation after performing a history and physical exam, transport to a trauma center but don't trauma alert.

## *Bypass Issues*

Have you noticed? Although we're in the dead of summer, Hillsborough's emergency departments never seemed to slow down from the winter tourist season as in past years. At least one hospital goes on bypass daily even after all the snowbirds migrated back North. What we're witnessing locally is mirrored statewide and nationally, fueled by the nursing shortage and financial crisis-state of healthcare.

It is such a problem that the State's Department of Health and the Agency for Health Care Administration have appointed an Emergency Services Task Force to study and make recommendations concerning issues assigned by the Florida Legislature in HB 1991, including the diversion of EMS services, hospital and ER closures, specialty staffing shortages and the cost of providing emergency services. The Task Force anticipates holding a total of five to six meetings to complete its work. A final report is due to the Florida Legislature by January 1, 2001.

The Task Force's second meeting (the first was a teleconference) was an all-day workshop held in Tampa on August 29, 2000. Many representatives from Bay area hospitals attended. The Task Force heard from numerous invited speakers and the public. After the presentations, the group broke into three subcommittees to discuss ED staffing and services, diversion from the ambulance and hospital perspectives, and costs/compensation, particularly the impact of unfunded mandates and uncompensated emergency services borne by physicians, hospital-based emergency services and EMS providers. Future Task Force meetings were scheduled. Check the list of future meetings listed at the end of this newsletter for those dates.

There were no suspected infractions to investigate since the last newsletter but there were prehospital concerns expressed re: timely prehospital access to

care. There have been instances in which a rescue crew has felt pressured to transport an unstable patient beyond a nearer "diversion status" hospital to a further "open" hospital.

The committee recommended that EMS should never bypass a hospital on diversion with a critical patient, emphatically citing the courtesy nature of bypass. EMS must keep in mind that an ED staff's attempts to confirm its bypass status when called on the radio about an incoming patient should not be construed as refusal to accept that patient. If there is an unpleasant interpersonal encounter between EMS and ED personnel, each EMS agency does have recourse. To pursue grievances about EMS-nursing or EMS-physician interactions, contact the appropriate ED nurse administrative personnel or the medical director for that ED respectively. Contact information is available upon request if you don't have a current list of committee members. Please call Barbara Uzenoff at the Trauma Agency for a referral at 276-2051.

**THIS NEXT SECTION, SIMPLY CALLED 'TRAUMA VIGNETTES', WILL BECOME A REGULAR FEATURE OF FUTURE NEWSLETTERS. WE HOPE THAT THE ILLUSTRATION OF SELECTED PREHOSPITAL CASES ACCOMPANIED BY BRIEF CRITIQUES CAN BE A USEFUL AND ENJOYABLE WAY TO RECEIVE ONGOING CLINICAL GUIDANCE FOR THE REAL-WORLD CHALLENGES THAT PREHOSPITAL PROVIDERS FACE IN THEIR CAREERS.**

**PLEASE TAKE SOME TIME TO READ THESE EXAMPLES AND TELL US WHAT YOU THINK ABOUT THIS CONCEPT, THE CONTENT, FORMAT, ETC., ETC., OR WHATEVER YOU WANT, JUST TELL US !**

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## ***Trauma Vignettes***

### ***Vignette #1***

A 63 Y.O. female, was a restrained right front passenger in a car hit head-on. She was observed to be responsive to deep pain only with labored breathing upon rescue's arrival. Food was swept from her mouth to clear the airway. O<sub>2</sub> was administered via NRBM. Initial VS were BP: 100/palp, P of 100, RR of 16 and GCS of 4. After extrication, her respirations decreased, so an oropharyngeal airway was inserted and she was bagged instead. She brady'ed down to 30. CPR was instituted with BVM. Orotracheal intubation was attempted x 3 unsuccessfully. A Combitube was inserted. EMS was unable to establish IV.

The crew observed that there was no obvious signs of trauma to head, chest or extremities and documented that the patient's condition appeared to be of "atraumatic origin". The transport was called in as a Code 19.

Upon arrival at trauma center, an in-hospital trauma alert had to be called. A chest tube placed in left pleural cavity released a copious amount of blood. The patient expired an hour later despite all efforts.

The cause of death was determined to be laceration of the lung and pulmonary artery with hemothorax due to blunt impact to the head and torso and fracture of the second cervical vertebra.

Cases like the one presented above where prehospital incorrectly assumed an medical rather than traumatic etiology during their assessment happen possibly more often than you might think. We'd like to reverse that kind of thinking. In this example, even though there were no visible signs of traumatic injury, one would be well served by having a heightened degree of suspicion about why a passenger in an auto accident would be suddenly become unresponsive. Think

about what the likelihood would be of an occupant in a car accident suddenly suffering from some medical crisis completely unrelated to the MVA.

If the patient was the driver in this example, that would have been a whole different scenario, but we're talking about the passenger. Clearly, trauma should have been an utmost priority in these care givers' minds. A different mind set in this particular incident probably wouldn't have made a difference in the outcome, but clearly, the rescue crew didn't appreciate what was happening to the patient here. More importantly, they could well come across circumstances in the future where proper assessment and intervention could improve chances for survival.

The following is another case to ponder under the heading "Is this medical or trauma?"

### ***Vignette #2***

A 74 Y.O. male fell from standing height to the sidewalk. He was found apneic, unequal and non-reactive pupils, and signs of head and extremity trauma. His initial VS were BP: 100/palp, P 80, RR 4, with a GCS of 3. The patient was intubated and transported emergently to trauma center but not trauma alerted. The trauma center treated the patient as a trauma alert and summoned the trauma surgeon immediately.

The patient expired three days later after being made a DNR. The cause of death was bronchopneumonia as a consequence of cerebral contusion due to blunt impact to head. He had bilateral subdural and subarachnoid hemorrhages, a pneumothorax and fractured right ribs.

In this case, the medics thought this patient was a stroke victim. Prehospital had talked to witnesses at the scene who saw the patient staggering first before falling down.

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Should this have been a stroke alert or a trauma alert? It is probably unfair to fault this crew, even though they probably could have done a better physical exam. They attributed his behavior to an evolving cerebral event immediately pre-fall. However, one cannot lose sight of the fact that just because a medical cause triggered the incident, that there could also be concomitant trauma to contend with. They did not pick up on the pneumothorax or broken ribs.

Was this next patient taken to the appropriate facility? Read on.

### ***Vignette #3***

A 61 Y.O. male went outside the house early one morning. His wife went looking for him when he did not return. He was found on the ground, incontinent of urine, acting confused, bleeding from one ear and c/o back pain. Prehospital was summoned. EMS observed patient's incontinence, bleeding around the right ear, c/o mid back pain, moving all extremities and confused to person place and time which was new according to the wife. He told his wife he had been doing exercises at the time. An inventory of his current meds included Lotensin, HCTZ and Synthroid.

His initial VS were BP: 160/120, P 70, RR 16 and GCS of 14. The Accu-Chek BS was 169. A NTG was given SL. The second set of VS were BP: 157/97, P 76, RR 20. He was transported non-emergency to a non-trauma center.

The initial receiving ED evaluation revealed an acute mental status change with confusion and a BP of 143/93. The CT of brain showed traumatic subarachnoid bleed in the sulci of left cortex, 2.0 to 3.0 cm size contusion, and neither intraventricular blood nor mass effect. It turned out that the blood in his ear had come from his tympanic membrane and that he suffered from some chronic mastoid disease. The patient finally admitted to falling off his son's roof

when confronted by his wife. He was admitted to ICU at same non-trauma center.

Did the paramedic exercise the correct judgement in his assessment? Arguably, this is another example of ignoring or downplaying signs of trauma. This patient's condition was assumed to be medical. Any time there is an acute mental status change and evidence of some trauma, shouldn't that patient automatically be transported to a trauma center? You can't tell the difference at the scene between a spontaneous or traumatic bleed. CT is not always readily available at non trauma centers. Should some discrete measures be developed and incorporated into the trauma triage criteria to define these types of cases? We'd like to hear from ED docs, especially those at non trauma centers, on this one. Tell us what you think, write to the Editor.

### ***Vignette #4***

An 84 Y.O. male who was an unrestrained driver, collided with parked car. EMS found NTG in the car. The patient's initial VS were BP: 60/palp, P 80, RR 24, a GCS of 11 with an Accu-Chek of 477. An IV bolus of fluids raised the BP to 80/palp, P 80, RR 24. His arms were noted to be "flaccid bilaterally w/ unequal grip strength". EMS did not document leg movement. No trauma alert was called because it was thought the MVA was 2° to an unknown medical condition.

At the hospital, the patient c/o weakness in all four extremities. X-rays revealed subluxation of C<sub>4</sub> on C<sub>5</sub>. He underwent a surgical reduction, discectomy and fusion, but subsequently succumbed to lobar pneumonia and sepsis three days later.

Here we go again down the medical pathway. Prehospital should have called a trauma alert. They did not document leg movement so we have to conclude that there was an incomplete assessment of the extremity weakness. At least the patient went to a

trauma center. Also, there seems to be some hesitance in calling trauma alerts for elderly patients as evidenced by some of these case examples. Is this a widespread and fair perception? What are your thoughts on this? Would you write in and share them with others?

### *Vignette #5*

An 88 Y.O. female fell at home, witnessed by the family, who then told EMS that she was not acting herself afterwards, and had altered LOC. They also supplied the background that she had been sick with cough and fever for two days prior. Prehospital found evidence of facial trauma present. The patient was c/o weakness but moving all extremities. Her Accu-Chek was 188. The initial VS were BP: 160/80, P 104, RR 18 and a GCS of 12. No trauma alert was called. She was taken to a non-trauma center where x-rays revealed an acute left subdural hematoma. The patient was transferred to trauma center later that evening but subsequently made a DNR because of pre-existing illness and age.

A trauma alert could really have been called for this elderly patient but the situation was clouded by this patient's other pre-existing 'medical' complaints. We would like to see these types of patients about whom there is substantial uncertainty at least go to a trauma center if not trauma alerted. Are there any comments about this?

Another missed elderly trauma alert follows. Let's see how this one was handled.

### *Vignette #6*

An 86 Y.O. female who suffered a witnessed fall at home, hit the back of her head in the act and lost consciousness for 1-2 minutes. This LOC was followed by a headache, N & V and subsequent LOC again. EMS found the patient unresponsive on their arrival with a hematoma to back of her head. Her VS were BP: 160/90, P 60, RR 25 and a GCS of 6.

They intubated the woman and transported her to a trauma center but did not call a trauma alert.

In the ED, a CT of her head revealed a basilar skull fx with a right subdural hematoma, cerebral edema and herniation. Several days later, the family agreed to withdraw supportive care and the patient expired.

What do you think set this case apart from the previous example that compelled prehospital to handle the situation differently? This patient legitimately also could have been trauma alerted but at least the patient went to a trauma center.

## **THE FOLLOWING IS A DESCRIPTION OF THE SETTING FOR OUR COUNTY'S UPCOMING ANNUAL RITUAL, THE LARGE-SCALE MASS CASUALTY EXERCISE, AND THE PURPOSE FOR OUR CONDUCTING THIS IMPORTANT EVENT.**

### ***SCENARIO: MASS CASUALTY 2000***

It was a dark and stormy morning. A band of severe thunderstorms associated with a rapidly moving cold front was lashing portions of Tampa and Hillsborough County. The National Weather Service at Ruskin had already issued a severe Thunderstorm warning, and much of the County was under a tornado watch.

At Armwood High School, morning classes had just begun. Students were just settling into their first class and, because of the threat of severe weather, students in temporary classrooms were preparing to move into the main building. However, their departure was delayed because a ferocious thunderstorm had moved over the campus. As students waited for the wind driven downpour to subside, they heard the sound of large hailstones smashing against the sides of their buildings.

Suddenly, the rain and hail stopped. It was as if a huge faucet had been turned off. For a moment there was an eerie silence. Then, the buildings began to shake and there was a roar like few had heard before. It sounded like a huge jet plane with engines screaming was about to crash into the school. Terrified students looking out the windows didn't see an airplane. Instead, they saw a huge swirling black cloud bearing down on the campus. A tornado was about to rip into the school.

Within seconds, the swirling cloud engulfed the campus. Lights went out as the storm tore down power lines. The screams of the terrified students were drowned out by the howling winds. Windows disintegrated, and the temporary classrooms were torn apart. The main building shook, as windows broke, showering the students with glass and debris.



Within it was over. rain continued over the of the school.

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damage was overwhelming. A Force 2 tornado with winds in excess of 150 mph had hit the school. Most of the temporary classrooms were destroyed, and the main building sustained major damage. The campus was covered with debris. The bodies of several victims lay in the parking lot. Hundreds of students, many severely injured, began emerging from the wreckage of what had been their school.

Within minutes, the first responders arrived on scene. As the incident commander saw the extent of the damage, he called for all available units. Soon, the streets around the school were filled with County Sheriff's Deputies and Tampa Police and Fire/Rescue units. Local news trucks rolled onto the scene and the air was filled with law enforcement and news

helicopters. As word spread about the extent of the disaster, hundreds of distraught parents began converging on the school. Events were rapidly spiraling out of control and the disaster site was rapidly descending into chaos.

**WHEN:** October 18, 2000

**WHERE:** Armwood High School

**WHAT:** A strong Force 2 Tornado strikes Armwood High School resulting in many deaths and hundreds of injuries



**WHO:** 14 hospitals and 4 surgical clinics, 800 - 1000 student casualties from Armwood High School, County and City Fire Rescue, County Sheriff, local media, RACES, School Board Transport, Share-A-Van, AMR and AMC Ambulance Services and others.

**EXERCISE OBJECTIVES**

**PRIMARY:**

To test the ability of the County's 14 hospitals and 4 surgical clinics to receive and treat a sudden mass influx of casualties.

**SECONDARY:**

To test the ability of the Tampa and County Fire / Rescue to triage and transport patients from the disaster site to the hospitals.

To test the County EOC communications system.

To test the Incident Command System in a mass casualty scenario.

To test the ability of the County Sheriff and County Fire Rescue to respond in a timely manner and to request emergency mutual aid from the City of Tampa.

To test the triage system at the disaster site and at the receiving hospitals and surgical clinics.

To test hospitals' priority discharge / bed availability reporting system.

To activate and test the county mass casualty communications network, to include activating RACES and testing their capabilities.

To test Red Cross communications, and patient tracking procedures.

To test Red Cross ability to establish a holding area for victims' family members near the scene.

To test the ability to establish and operate a Joint Information Center. (JIC).

***“Letters to the Editor” Corner***

We received several items for submission to the ‘Corner’ for this edition. Thank you. Please, keep the letters coming in!

*Q:* In the March 2000 HCTA Newsletter, we were told that the Bypass Committee had concluded after a review of recent incidents that EMS should not call the hospitals to ask if it is OK to bring certain patients to a hospital on bypass. This

would work except that the hospitals give a lot of attitude to EMS providers that don't call in prior to arrival at the ER. So, how would an EMS provider call the hospital with patient report and not get a response based on the hospital's bypass status?

*A:* I hope providers are not missing the point here. What the Bypass Committee meant was that EMS should not ask a hospital on bypass for clearance or permission to bring a particular patient to them. If the patient is not a trauma alert, only you and the patient (or patient care spokesman) should be deciding where the patient is to be transported. Once that decision is made, your remaining obligation to that facility is to notify the staff of the incoming patient as per protocol.

*Yes, you may receive a response back on the radio to the effect of “Are you aware that we are on bypass?” This is because some hospitals have a policy requiring that they remind every EMS provider of their status whenever notified that a patient is en route to them. Unfortunately, depending on the speaker's inflection, the prehospital provider could very easily misinterpret this as admonishing behavior. Unfortunately, ever since there was bypass, there has been friction over its observance. We're used to it but no one likes this. Should we just accept this or work proactively to make a positive change?. Are there any suggestions for remedying this communication issue?*

*Q:* It was stated that we transport trauma alerts to Lakeland Regional Medical Center. I would like to mention that LRMC doesn't acknowledge "Trauma Alerts" as such and gives us a lot of grief for transporting patients to them from Hillsborough County, although I would say that they do give appropriate care.

*A:* I'm afraid I don't know what you mean when you say that LRMC doesn't acknowledge trauma alerts as such. They are a level II state-approved trauma center for adult trauma alert patients (>15 years). Barbara Galloway, Trauma Program Manager at LRMC, has assured the Trauma Audit Committee (TAC) that they welcome any trauma alert that HCFR may transport to them because of concern for patient instability and the need to divert to the closest appropriate trauma center.

*Keep in mind however, that they are not a pediatric trauma center. If the patient meets the definition of a pediatric trauma alert, or has a trauma alert category burn, or a suspected spinal cord injury, that patient should be transported to Tampa General. The TAC was also advised within the last year that the late Dr. Straub received personal assurances from Ms. Galloway that transporting*

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*adult trauma alerts to LRMC posed no undue hardship to their trauma program.*

*If you're receiving negative feedback from transporting a trauma patient not meeting trauma alert criteria, but have a specific reason for doing so, a patient falling into the gray zone (e.g., he/she doesn't meet criteria, you don't want to trauma alert but think the patient should go to a trauma center), or you are honoring the patient's destination request, I would urge you to report such an incident to your supervisor who will take it up with your QI Chief who will bring it to the attention of the TAC if appropriate.*

*Q: Could you please explain what 'SAPTRC' and 'BSCIP' mean?*

*A: 'SAPTRC' is the State's abbreviation for a pediatric trauma center. It stands for State Approved Pediatric Trauma Referral Center.*

*'BSCIP' is the acronym for the Brain and Spinal Cord Injury Program. It is a designation awarded to institutions who comply with the standards and criteria established in the State Plan. Although special credentialing such as this State designation can never guarantee the level of care provided, just as in trauma center approval ratings, it signifies that a provider has made a commitment and put in place the necessary infrastructure deemed essential to ensure optimal outcomes. A BSCIP designation does not require a facility to be a trauma center. Nor are the requirements identical to those for trauma centers. Finally, the State-approved adult and pediatric trauma center standards do not confer BSCIP status upon a trauma center. The BSCIP used to involve a separate site survey from that for trauma center approval. That is changing now since that division under the Department of Vocational Rehabilitation has merged with the Bureau of EMS and joint site surveys are planned for the future.*

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***Upcoming meetings/events/training***

- ▶ Cardiac and Stroke Alert Committee, EOC, 9/13/00, 0900
- ▶ Special Needs Shelter Operations Class, EOC, 9/19/00, 1800-2100 (3 CEUs offered - taught by Red Cross and County Emergency Management)
- ▶ Third Emergency Services Task Force Meeting, 9/27/00, Panama City (tentative)
- ▶ EMS Advisory Council and Constituent Meetings, Miami, 10/4-10/6/00
- ▶ Fourth Emergency Services Task Force Meeting, Miami, 10/4/00 (tentative)
- ▶ Fifth Emergency Services Task Force Meeting, Jacksonville, 10/11/00 (tentative)
- ▶ Emergency Medical Planning Council, EOC, 10/17/00, 1400
- ▶ Annual Mass Casualty Exercise, Armwood High School (direct hit from Force 2 tornado 112-157 mph), 10/18/00
- ▶ Down and Dirty III, a CEN Review, Bayfront Medical Center, 10/23/00, 0730-1700
- ▶ HCFR Staff Report to BOCC on Staffing and Response Times, County Center, 12/6/00, 1600

Articles, news and other information of interest to the trauma community may be submitted for consideration for publication by the HCTA.

If you have questions or concerns about trauma care in Hillsborough County that you would like to see addressed in the newsletter, please submit your letters to the Editor as follows:

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*HCTA Newsletter is published by the Hillsborough County Trauma Agency to inform and advise its prehospital, hospital, rehabilitation and emergency medical dispatch constituents about trauma system issues, standards of care, and legislation affecting providers locally and statewide. For more information, contact Barbara Uzenoff by phone (813) 276-2051, fax (813)272-5346 or E-mail UzenoffB@HillsboroughCounty.org.*

**HILLSBOROUGH COUNTY**  
*Board of County Commissioners*



*Hillsborough County*

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Address label