



HCTA Newsletter

Volume 5 Issue 1

May 2002

Countywide Hospital Bypass Update

Hillsborough County Hospital Diversion for Calendar Years 2000 & 2001

Hospital	CY00 Pt. Volume	CY00 Div Hours	% Share Total County Div Hrs for CY 00	CY01 Pt. Volume	CY01 Div Hours	% Share Total County Div Hrs for CY01	% Pt. Vol Incr/ Decr from 00-01	% Div Hrs Incr/ Decr from 00-01
Brandon	65,000	811	12%	67,059	2,738	21%	3% inc	238% inc
Memorial	15,000	283	4%	14,477	1,877	14%	4% dec	563% inc
SB	17,000	665	9%	17,778	551	4%	5% inc	17% dec
SFB	36,606	363	5%	39,836	456	3%	9% inc	26% inc
SHI	93,000	1,268	18%	100,242	1,442	11%	7% inc	14% inc
T&C	17,000	49	<1%	20,857	199	1%	22% inc	306% inc
TGH	53,567	91	1%	58,961	170	1%	10% inc	87% inc
UCH-C	32,000	1,449	21%	34,263	1,843	14%	7% inc	27% inc
UCH-F	64,000	1000	14%	67,567	1,180	9%	5% inc	18% inc
VA	12,000	1027	15%	13,293	2,586	20%	11% inc	152% inc
All	405,173	7,006	---	434,333	13,042	---	6% inc	86% inc

For the second year in a row, Hillsborough hospitals have been voluntarily submitting their hours on diversion to the Hospital Bypass Committee, a subcommittee under the Emergency Medical Planning Council which is an advisory body to the Board of County Commissioners. For the first time we have the opportunity to compare consecutive years of activity to see change over time. What the data shows us is what hospital and ED administrators already had a gut feeling for, that they are seeing more patients and going on bypass more frequently. The percentage increase in hours on bypass, however, is disproportionately greater than the rise in patient volume.

Diversion is a complex issue, a problem experienced by hospitals nationwide and is not simply an end result of the nursing shortage. The Florida Legislature enacted legislation that provided for the appointment of a task force to study the root causes leading to diversion and report to the Governor, the President of the Senate and

the Speaker of the House of Representatives by January 1, 2001. This State EMS Task Force Report which contains a summary of the findings and includes a set of recommendations is located on the Trauma Agency's web site in Adobe Acrobat format at <http://www.hillsboroughcounty.org/publicsafety/trauma/documents.html>

Internet-based Bypass Activation / Notification and Reporting System Coming

By late summer, Hillsborough County hospitals can expect to be using the Internet to directly notify ambulances of their intent to go on bypass. The Bypass Committee identified as a major shortfall of the current system that individual hospitals lack awareness of ongoing bypass activity elsewhere in the County because diversion status was manually tracked by each facility. The Committee believes that a web-based service that will provide the capability to continuously monitor the real-time bypass status of all Hillsborough's EDs simultaneously could have many potential benefits to our community. They feel that if the EDs have a continuous 'big picture' view of all the facilities' status, individual institutions will be able to initiate timely proactive measures that could conceivably avert episodes of diversion. Nurse managers and hospital administrators have long appreciated how the temporary closure of one ED can set off a ripple effect across the community, leading to the overcrowding and closures of other EDs. Being able to see the community at-large will help all manage diversion as a community issue.

The Hospital Bypass Committee has been exploring potential vendors over the past two years to accomplish this goal. In the fall of 2001, the Committee conducted an on-line side-by-side comparison of two possible applications. One of the services evaluated was part of a suite of products (LEADERS) offered by the several technology companies (Oracle Corporation, EYT,

formerly Ernst & Young Technologies, ScenPro, Inc., and Idaho Technology, Inc.) that support the medical surveillance system that Hillsborough EDs currently use to track emergency visits to detect bioterrorism events and naturally occurring outbreaks. This (CCT or critical care tracking) module allowed hospitals elsewhere to track critical care bed status and was used real-time to make interfacility transfer decisions between hospitals within the same corporate healthcare system. The diversion portion of the package was limited to showing EDs as only open, closed or on reroute status, and more importantly, had no provision for notifying the ambulances of this information by pager. At the time of the evaluation, the Oracle representative could offer no reasonable expectation that a customization of this system was either possible or forthcoming, and as such, it was not considered a viable format for Hillsborough County.

The other vendor evaluated, EMSsystem (Infinity Healthcare), was already established in 20 metropolitan areas nationwide. It had a good track record and an application design that already closely matched our county's needs. The drawback was that there were substantial initial regional start-up costs plus annually recurring fees that would have had to be borne by the hospitals.

In the spring of 2002, the Bypass Committee was in the process of determining the level of hospital support countywide for the EMSsystem project when EYT approached County advising of their willingness to redesign their application to meet Hillsborough's hospitals' bypass needs, and best of all, it was included in the federally funded LEADERS medical surveillance package already implemented in all hospitals in the County. This fortunate turn of events came about when EYT and Oracle came to an agreement allowing EYT to take over all the application modifications and enhancements for LEADERS users. This internal business arrangement was finalized in April and was the principal reason why the Hillsborough customization to the CCT module could be implemented.

Hospitals are being officially notified to prepare for this change in bypass activation/notification procedure by assuring that computers with Internet access are available in the EDs. No special software is required, only a web browser. Training in the process will be provided on-line and via teleconference by an EYT representative.

All status changes entered into the system by any hospital will be sent as alpha-numeric page messages to all hospital and prehospital providers via the current pager group number that is hard-wired into the "bypass" pagers. Additional "regular" pager numbers will now also be able to be programmed to notify other field personnel, hospital staff and administrators of bypass activity. The application can even be made to send e-mail notifications of bypass status changes to selected addresses. Each facility will be issued several institutional passwords. Only authorized users may make entries into the system and the author of each change will be part of the permanent record.

There will be a message board to enable hospitals to notify other hospitals or EMS about particular internal conditions. Furthermore, this system can be used to communicate with Hillsborough County's Emergency Operations Center during disasters or mass casualty incidents to relay bed capacity and number of patients able to be triaged to EDs instead of faxing the information. Clearly, a major advantage of the service will be improved efficiency of operations.

Reports will be able to be easily generated, either from within the program or by exporting to an Excel format. Each hospital will have sole access to its own historical information. The data will be extremely accurate because there will be no potential for loss of information, no misplaced forms, etc., and the source data will have been entered onto a secure server. And the ED managers and clerical personnel will certainly not miss having to prepare a monthly bypass report for the Hospital Bypass Committee.

Hillsborough County Enhanced Disease Surveillance System

Eliot M. Gregos, MPH, Environmental Epidemiologist and Jordan Lewis, Director, Environmental Health and Epidemiology Hillsborough County Health Department

On November 1, 2001, Hillsborough County became the first county in the US to initiate an ongoing enhanced medical surveillance system utilizing emergency visit data to detect potential bioterrorism events as well as naturally occurring outbreaks, such as influenza, food borne and waterborne illness. There are currently nine hospitals participating in the program.

- Brandon Regional Hospital
- Memorial Hospital
- St. Joseph's Hospital
- South Bay Hospital
- South Florida Baptist Hospital
- Tampa General Hospital
- Town and Country Hospital
- University Community Hospital – Carrollwood
- University Community Hospital – Fletcher

The initial patient information is put into a web-based system developed by the Oracle Corporation, Ernst & Young Technologies and others called LEADERS (Lightweight Epidemiological Advanced Detection and Emergency Response System). LEADERS is a suite of software designed to provide medical surveillance, emergency department diversion status, bed availability and other critical care services on a real time basis.

The medical surveillance system uses a syndromic surveillance model originally developed by the Centers for Disease Control and Prevention (CDC) for monitoring large gatherings such as sporting events and political conventions. It was first used in Hillsborough County on a short-term basis during Superbowl and Gasparilla 2001. At present, hospital emergency departments enter data on a real-time basis into a secure database via an Internet connection. Hillsborough County Emergency Dispatch runs an aberration detection analysis twice daily, seven days a week. This program

compares the current numbers of cases of the various syndromes with their running means using several methods. Any significant detections are immediately reported to the Hillsborough County Health Department who reviews the data and follows up with hospital Infection Control departments and patients as necessary.

The results from this emergency department surveillance has mirrored the types of illnesses that were being seen in the community at the time. In late December we saw an increase in diarrhea and gastroenteritis in the ED's that flagged the system while at the same time this was being detected in our schools, day cares and also clinics, probably a type of rotavirus. In mid-January the same thing happened with upper respiratory flags which also coincided with our peak influenza-like illness time.

In addition to communication with the hospitals when unusual patterns of illness are detected, weekly volume reports provide feedback to the hospitals. Comparing these reports with internal census figures allows them to track their own consistency of reporting. Monthly quality assurance reports allows hospitals to compare their performance, accuracy, and timeliness with that of the other participating hospitals.

The Hillsborough County Health Department would like to thank the participants for their outstanding assistance in keeping our community safe through this unique surveillance for unusual health events.

Update on the Tampa Bay Metropolitan Medical Response System (MMRS)

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

Here is the latest update on the efforts to develop a MMRS System capable of responding to a terrorist incident in Florida Region 4.

A bio terrorism surveillance system has been installed in nine County hospitals with emergency rooms. Jordan Lewis from the County Health Department discusses this system in detail elsewhere in this newsletter. Pharmaceutical caches capable of treating 1000 victims

of a chemical attack or 10,000 victims of a biological attack for the initial 24 hours have been procured and are being distributed to thirteen of fourteen County hospitals.

The State Department of Health (DOH) is in the process of procuring additional stores of pharmaceuticals and protective equipment to be placed in each of the State's nine regions. These regional caches will be used to supplement local capabilities. In conjunction with County Health Departments and local MMRS Committees and Emergency Managers, the State DOH is also developing a plan to request receive and track the distribution of pharmaceuticals and equipment that comprise the Federal Pharmaceutical Caches. As a result of these efforts, we now have a better definition of roles and responsibilities in this vital area.

Melissa Hiller and Eric Gentry, PhD Candidates at USF who are co chairing the MMRS Mental Health Workgroup, applied for and were awarded a \$119,000 competitive grant to establish a mental health support system capable of responding to any major disaster. The grant will pay for the establishment of a full or part-time mental health coordinator position. This individual will serve as a focal point for coordinating mental health volunteer support and developing a standardized training program. Melissa and Eric are to be congratulated for their hard work in this area.

An approved list of hospital decontamination equipment has been provided to Kern Wilson, the City of Tampa Emergency Coordinator. As of this writing, the request is still wending its way through the City of Tampa Purchasing Department. When received, the equipment will provide all participating hospitals with level "C" Personal Protective Suits. In addition, all participating hospitals will receive portable decon showers. The vendor has also agreed to provide the initial training to hospital staffs on the wear and use of all equipment.

Over 50 local physicians have signed up to serve as emergency medical volunteers during a major disaster. A data base has been developed to maintain a listing and letters will be sent to all volunteer to thank them for their willingness to help.

Dr. Jacqueline Cattani, Professor of Tropical Health, College of Public Health, University of South Florida, has developed and distributed a proposed training matrix for hospitals. The goal of the template is to develop an ongoing training program that will:

- Identify the hospital staff to be trained
- Define the type of training needed.
- Decide how best to provide the training (tapes/ lectures etc.)

We have come a long way in the past year. However, much remains to be done. Preparing to respond to the consequences of a terrorist act will be an ongoing project. This is one area where we can't afford to let up on our efforts.

Digital Radiology System in use at St. Joseph's to Speed Care for Patients

J. Michael Hance, MHA, Director Ancillary Services, St. Joseph's-Baptist Health Care

St. Joseph's Hospital has introduced leading edge digital technology in its Radiology Department that will speed patient care for its emergency and inpatient departments. In an era where patients and physicians demand quicker testing for faster diagnosis and treatment, St. Joseph's is the community leader with the installation of the first phase of PACS, Picture Archive and Communications System, in September 2001. The GE Medical PathSpeedÒ system offers filmless images throughout St. Joseph's main campus, including its Emergency Center, FirstCare for Minor Adult Injuries, CT, MR and Diagnostic Radiology. This filmless information management system will be fully operational throughout the St. Joseph's system within the next 24 months. Ultrasound and Nuclear Medicine modalities will be added as well as viewing stations in all critical care areas, surgical suites, and outpatient diagnostic centers.

According to St. Joseph's Chief of Radiology Matt Berlet, M.D., patients suffering from stroke, heart attack or trauma injuries have been the first ones to benefit from

the PACS technology. "With this technology, physicians and radiologists reading images can pull up a patient's file simultaneously from different locations to accelerate diagnosis and treatment," Berlet said. "For emergent diagnoses like stroke, every second counts to deliver the therapy that patients need."

SJH Chief Operating Officer Fleury Yelvington said the new system saves time and eliminates multiple steps for physicians to review and receive radiology images of their patients. This is important, as SJH processes more than 1,400 X-rays, CTs, MRs, ultrasounds, nuclear medicine and interventional procedures each day among the imaging service areas throughout its campus.

Yelvington adds, "Filmless radiology means better care for patients by speeding images to their physician, even doctors with remote access, so they can view CTs, MRs and other images almost immediately after the image is taken. This is St. Joseph's latest investment in technology which advances the diagnostic excellence we offer our patients."

Part of the PACS installation includes an information management system that runs a sophisticated database to manage the intricate flow of patient and exam information throughout the hospital. Firewalls, user identification and passwords keep encrypted patient information accessible only to authorized physician and hospital staff, even from remote locations.

The PACS software serves as a "virtual front office" for SJH staff by storing and managing patient demographics, exam information, diagnostic and department information, and ancillary data. If a patient comes into St. Joseph's through the Emergency Center or as an outpatient, the PACS system will automatically "pre-fetch" any previous images taken on that patient for the radiologist to review as they are interpreting their current radiology images. Hard copies of film are no longer stored, as all images are permanently archived on DVD storage media for future retrieval and use by radiologists or consulting physicians in managing patient care.

The PACS initiative at St. Joseph's will continue to expand, as this new digital radiology system represents an early phase of the emerging technology strategy for St. Joseph's. Expansion plans for 2002 include utilizing a server technology to enable images to be viewed in all five critical care areas of St. Joseph's as well as expanding viewing capabilities to St. Joseph's Women's Hospital, the operating suites, and the outpatient Diagnostic Center. The server web technology will also enable physicians to retrieve images from the PACS database to view in their office via their internet provider technology.

In conclusion, PACS increases patient and physician satisfaction and it reduces cost and wait times.

Florida's Trauma Registry Moves Forward

*Jessica Swanson, Planning Manager, Bureau of
Emergency Medical Services*

PURPOSE AND SCOPE OF TRAUMA REGISTRY

A trauma registry, as defined by the American College of Surgeons, provides for the collection, storage and reporting of information about trauma patients, including facts about the injury event, severity, care and outcome. The intent of the trauma registry is to collect data that may be used in the inclusive trauma system to measure performance standards and outcomes, to evaluate the cost, care and incidence of trauma injuries as a public health service, to evaluate trauma incidences and care as a public health problem, to facilitate research and to objectively review how care is provided across geopolitical regions (1999).

The Florida Department of Health, Bureau of Emergency Medical Services has been collecting data for over 13 years on trauma patients in Florida. In 1989, the Bureau was statutorily mandated to establish a trauma registry to collect data from State Approved Trauma Centers, State Approved Pediatric Trauma Referral Centers and acute care hospitals. This data would ensure compliance with section 395.404, F.S. and monitor patient outcomes. For years this information was submitted to the

Department of Health in various types of paper forms. In 1996, the Committee on Trauma encouraged trauma centers to purchase the Trauma Registry of the American College of Surgeons (TRACS) software, to collect data they needed to manage the effectiveness of their programs. In 1997, the Bureau began research on software components that would collect data and perform analysis to report to trauma centers, and in 1998 purchased the TRACS data system.

The State has been working to develop and implement the electronic system and under the direction of Chuck Bement, Bureau Chief, the new registry is up and running. Several key projects were initiated to move the registry into the technological era, including advanced training for several staff members, new computer equipment and upgrades and a supplemental grant awarded to help bring the 20 trauma centers together to address changing needs and updated goals.

Using Emergency Medical Services for Children supplemental grant money, the Bureau was able to sponsor a two-day trauma registry seminar. All 20 trauma centers and the trauma agencies were present in Orlando for computer training on November 7th and for an open forum seminar on November 8th. The seminar included discussions on various definitions, data submission requirements, state reporting, and establishing a task force to address registry issues. Representatives from the American College of Surgeons joined the group to address Florida's specific needs and possible customization of data points for the State. Pediatric data has always been complicated for trauma registries because of the differing needs of the population, but the Bureau's epidemiologist was able to work with the pediatric trauma centers to create a plan to collect the necessary data.

The seminar was a significant achievement in bringing the trauma centers, trauma agencies and state representatives to the table as part of an active registry. The focus through January 2002 was on reviewing the data submitted through the task force and presenting proposals to the Trauma Program Managers and the

Committee on Trauma for review and changes. The Bureau hopes to provide its first preliminary reports by spring 2002. Also in development is a web page that can be accessed by trauma centers for the specific goal of posting ideas, suggestions, questions and feedback to the Bureau as we move forward with an effective, efficient trauma registry.

After years of trauma centers providing data in paper format, the Bureau now accepts the electronic submission of trauma registry records. The evolution of the registry requires the state to build even stronger partnerships with trauma centers, trauma agencies and acute care hospitals, as we move towards our goal of an inclusive trauma system. The improved, comprehensive trauma registry will provide valuable data reporting and analysis, supporting this inclusive system in the provision of care for the most seriously injured trauma patients.

New Critical Intervention Devices Debut

Laurie A. Romig, M.D., FACEP, Bayflite and LifeNet 5 Co-Medical Director

In the never-ending search for improved patient care, several new critical intervention devices have been added to the armamentarium of the Bayflite and LifeNet 5 air medical services. Although individual ground services may have been using one or both of these devices, this is the first time for area air medical services. The Intubating Laryngeal Mask Airway (ILMA) and the F.A.S.T.-1 sternal intraosseous infusion device were implemented in January and February of 2002, respectively.

The main focus for implementing these devices is to provide as many noninvasive, or relatively less invasive, critical resuscitation options as possible. Though air medical crews are trained to perform surgical cricothyrotomies and central lines, these procedures carry added risk for both the patient and the provider. Another airway rescue technique, retrograde intubation, is also available, but so far has proven disappointing in the prehospital patients that Bayflite and LifeNet 5 encounter. Both the ILMA and F.A.S.T.-1 are last

resort interventions prior to surgical intervention; they will not be used routinely. It is estimated that the ILMA will be used less than a half dozen times per year, and the F.A.S.T.-1 a bit more often.

All of the primary flight receiving hospitals have been inserviced on both devices. The ILMA is not disposable; aircrews will remain with the patient to retrieve the device as soon as endotracheal intubation is accomplished. (Note that endotracheal intubation can be accomplished via the ILMA, but this is not required per protocol.) The F.A.S.T.-1 device must only be removed with a special tool included with the kit. The tool will be left with the patient if other venous access has not been established prior to aircrew departure; otherwise the aircrew will remove the device. Each ED should determine to whom the removal tool is given or where it will be put, so that the location is always consistent. Close cooperation between nursing staff and physicians, especially rotating residents, will help to ensure that the device is removed properly.

Each use of either device will be immediately QA'd by the flight program. Any questions or concerns can be directed to the Chief Flight Nurse for your area, to the Chief Flight Nurse for the crew involved with an individual case, or to Medical Directors Laurie Romig, Charlie Sand, or Mike Lozano. Bayflite/LifeNet 5 will also be happy to provide further inservices if requested.

Drawing blood that could become a specimen for the Medical Examiner

On a number of occasions, the Medical Examiner's Department has regrettably had to discard tubes of blood because they were not labeled with the patient's name. Sometimes this unidentified blood that was handed over to AMR, the ambulance service that hold the transportation contract between the hospitals and the county morgue, was drawn by EMS in the field, and other times the blood was drawn in the EDs. Whenever possible, the pathologists try to obtain pre-treatment blood when doing their examinations. Please know that

your cooperation will be greatly appreciated.

6th Annual Trauma Symposium

The Sixth Annual Trauma Symposium was held Friday, May 17, 2002 at the Dale Mabry Campus of Hillsborough Community College.

The keynote speaker for this year's conference was Norman E. McSwain, Jr., M.D., F.A.C.S. Dr. McSwain, who besides being the associate director of trauma, professor of surgery, and director of the residency program at Tulane University, is the police surgeon for the city of New Orleans, and medical director of the New Orleans Jazz Festival. He has published extensively, pet interests are pre-hospital care, trauma and emergency medicine.

As in previous years, CMEs and contact hours to benefit physicians, nurses, paramedics, EMTs, emergency medical dispatchers and respiratory therapists were awarded.

As a special bonus, in support of EMS, to celebrate EMS Week, TGH held its annual barbeque in conjunction with the 6th Annual Trauma Symposium. Attendees were treated to complimentary barbeque chicken with all the 'fixins' immediately following the conference.

We would like to acknowledge and thank Dr. Lewis Flint, our Course Director, and our Program Planning Committee for their time and assistance in selecting this year's conference topics and speakers.

William Corso, RN, EMT-P
EMS Programs Manager
Hillsborough Community College

Cathy Maloney
Former Cont. Ed Coordinator
Hillsborough Community College

Rick Hodges, M.D.
Trauma surgeon
St. Joseph's Hospital

Lauren Stewart, ARNP
Trauma Program Manager
St. Joseph's Hospital

Cindi Hughlett
CME Coordinator
Tampa General Healthcare

Barbara Uzenoff, RN, MPH
Trauma Coordinator
Hillsborough Co. Trauma Agency

Celeste Kallenborn, RN, MBA
Trauma Program Manager
Tampa General Healthcare

Michael van Hoek, EMT-P
Instructor, Hillsborough
Community College

News from St. Joseph's Hospital

*Nancy J. Bickel, MSN, RN, TNS, Director,
Emergency/Trauma Services, St. Joseph's Hospital*

Andrea O'Lenick, RN, BSN, CEN is the new Adult ED Nurse Manager for St. Joseph's Hospital. Andrea comes to us from within the BayCare System from Morton Plant's Emergency Department as well as large urban trauma centers in New York and New Jersey as EMT/Paramedic/LPN and RN. We are excited about her addition to our Emergency/Trauma Administrative Team. She can be contacted at 813/554-8776. Please join us in welcoming her to St. Joseph's and Hillsborough County.

I am also pleased to announce that Sally Kitzmiller-Robelli, RN, accepted the new position of Trauma Program Coordinator for the St. Joseph's Emergency/Trauma Services Department. Sally started in this position last October. She previously was a CN2/Lead RN in the SJH Adult Emergency Center.

Sally is responsible for quality improvement and interdepartmental processes related to care of the trauma patients. Sally also coordinates the trauma-related educational programs. Sally can be reached at 870-4000, ext. 74595.

Please join us in congratulating Sally as she continues her career in this new endeavor.

Who Else is New?

There are a number of individuals who have assumed important positions in our trauma community since the last issue that we'd like to introduce to you here.

Tampa Fire Rescue Communications has two new personnel in supervisory positions. Both of them call the new Tampa Police/Fire Communications Building on Henry Avenue behind the EOC their new home.

District Chief Gary Parsons, EMT-P, replaced J.P. Phillips in October. Gary has been employed by TFR for 24 years, rising up through the ranks (Firefighter, Driver Engineer, Lieutenant, Captain). He was assigned to a rescue car for 10 years before being promoted to Captain, served on an Engine Company for four years and then an Aerial Company for another four years. Gary received his A/A from Chipola Junior College, an A/S from Hillsborough Junior College (Fire Science), B/S from University of South Florida (Education).

Margaret Hamrick, has been with Tampa Fire Rescue since 1986. She was the Training and Quality Assurance Coordinator before being promoted to Communications Operations Manager in February 2002. Margaret is a certified EMD through the National Academy of Emergency Medical Dispatchers, and has a Quality Assurance certification. Formerly the Coordinator of the Hillsborough Community College 9-1-1 Telecommunicator Program, she was responsible for implementing the new program curriculum. She is the Secretary for the Florida Association of Emergency Medical Dispatchers (FLAEMD). FLAEMD's purpose is to promote professionalism and integrity in public safety telecommunications through research and evaluation of the new and existing programs, technologies and interventions. FLAEMD is currently working on legislation to promote emergency medical dispatching throughout the State of Florida.

Tampa General Hospital also added to their ranks over the past few months. Kathie Gonzales, RN, BSN, came on board with the Trauma Office team in October. She is a Certified Surgical Technologist and Certified First Assistant and worked in the operating room for many years before going back to school to receive a nursing degree. Kathie also holds certifications as a Forensic Nurse Specialist and a Medical -Legal Consultant.

She, along with another trauma nurse clinician, follows all trauma patients throughout their hospital stays, performs case management, abstracts critical information for the

trauma registry and serves as patient care liaison for the families. In the near future, Kathie will also be taking on additional responsibilities teaching injury prevention classes for the staff and the community.

Sherry Swan, RN, BSN, also started in October as Clinical Research Nurse for the Trauma Surgery Department at Tampa General Hospital. She had been employed in the Department of Surgery here for two years prior to accepting this position. Her employment experience before nursing school was all law related.

Sherry received an AS in Nursing from HCC and a Bachelor's Degree from University of Tampa. She holds certificates in Legal-Nurse Consulting and Forensic Nursing and an additional license as a Healthcare Risk Manager.

Sherry is employed by USF and assists with research projects for the trauma surgeons as well as those funded by the pharmaceutical companies. She also assists the Trauma Office staff with their nursing research projects on trauma care.

The last time you read about David Jones in this forum was in the October 2000 issue when he joined South Bay Hospital as Director of Critical Care Services. He was recently promoted to Administrative Director of Nursing at South Bay but is still responsible for the Emergency Department.

News from Tampa General Hospital

Amy Paratore, RN, BSN, MBA, Director, Emergency & Trauma Services, Tampa General Hospital

TGH is proud to announce the addition of a new Attending Trauma Surgeon on the Trauma Service. Dr. Colleen Jaffray will be transitioning into her new role around July 1st. She is a familiar face, having been Chief Surgery Resident at TGH and the winner of the Florida Resident Paper Competition. In addition to her clinical

involvement in the management of our trauma patients, Dr. Jaffray will be very involved in research. We look forward to having Dr. Jaffray as part of our team!

TGH has also initiated our new Prehospital Trauma Educational Program, where members of our Trauma Service go out to different EMS agencies and present trauma educational programs and trauma case presentations to prehospital personnel involved in the initial care of the trauma patient.

In partnership with More Health, TGH was also the recipient of a state EMS grant to improve seatbelt use throughout our community. In the very near future, you will begin to see billboards throughout our community espousing the importance of seat belt use in the prevention of serious injuries from motor vehicle accidents. Additionally, "Buckle Up" window stickers will be distributed with oil changes from involved businesses. We truly are committed to providing trauma prevention programs to our community.

Radio communications have been vastly enhanced into TGH with the addition of a 100 foot communications tower and antennas onto the roof of TGH, courtesy of a another state EMS grant. Additionally, the Hillsborough County Sheriff's Office will be relocating their antennas onto our tower.

And finally, TGH is proud to announce the expansion of our Stroke Program. On March 1st, TGH improved their stroke program with the addition of a "Stroke Alert" paging system, dedicated on-call stroke attending physician, two new neuroprotective agent drug studies, and five neuro-interventional radiologists available 24/7 to provide intracerebral thrombolytic administration to acute stroke patients experiencing onset of symptoms less than six hours, significantly extending the window from three hours for peripheral tPA to six hours in angiogram. TGH is truly on the cutting edge for acute stroke care in our community!

Replacement Trauma Triage Pocket Guides Always Available!

Are your pocket guides falling apart? Call the Trauma Agency for replacements at 276-2051.

South Bay Hospital ED Expansion

Dana Litaker, Director of Marketing and Public Relations, South Bay Hospital

The much anticipated \$11 million expansion of South Bay Hospital's Emergency Department and Outpatient Waiting Area will become operational in late June. The new ED encompasses a \$2 million upgrade to the hospital's physical plant and will nearly quadruple in size from the current 4,000 sq. ft. to 14,000 sq. feet. The new facility is located north of the old ED and there will now be a separate patient walk-in entrance from the ambulance entrance. The old ED will probably be partitioned when renovated and put to various other uses.

The future ED will have fifteen treatment rooms (previously eight), two Trauma Rooms (previously one), the addition of four Fast Track Rooms and an eight bed fully monitored Observation Unit, plus an expanded Outpatient waiting area. EMS will also have a room of their own. There will be state-of-the-art therapeutic and diagnostic equipment, including the latest technology in cardiac monitoring, and a new Nuclear Medicine Camera.

This addition adds more than 27,000 sq. feet of new space and renovate 600 existing sq. feet of space. Approximately 125 additional parking spaces will be added to replace parking lost to construction.

From the Editor: Join Governor Jeb Bush and the South Bay Hospital team Monday, August 26th at 1:00 p.m. at South Bay Hospital for a formal ceremony where they'll be officially dedicating the opening of their new Emergency Department and unveiling the Bay area's first monument of its type honoring our every day heroes, our firefighters, police officers, nurses, physicians, EMS workers, our military and our veterans.

Trauma Vignettes

Brought to you by the Editor and Catherine L. Carrubba, M.D.

Vignette #1

An 8 year old girl was playing after school at a public park when she tripped and fell, hitting the back of her head against the bench of a picnic table. Her mother was nearby and witnessed the incident. The child continued to play for about another half hour but then stopped, c/o nausea, headache, and was thought to not be "acting normally". The mother became alarmed and drove her daughter to the pediatrician's office. At the doctor's office, the patient started vomiting and was medicated with 25 mg of Phenergan. While under observation, the girl started hallucinating and became combative.

The doctor's office arranged for the patient to be directly admitted to a non-trauma center pediatric unit and called Fire Rescue to transport the patient. When the paramedics arrived, they found the patient not immobilized, and difficult to arouse. She became violently combative when stimulated. They took the patients vitals and found them to be VS HR 92 RR 18 BP 112/68 with a GSC 10. The crew determined that she met state-mandated criteria for a pediatric trauma alert which meant they were compelled to transport her to a trauma center. This decision was resisted by the physician so the rescue unit contacted their medical director from the scene. The medical director upheld the paramedics' decision.

ALS immobilized the patient and transported to the closest trauma center. En route, they gave Valium IV for sedation, as ordered by their medical director. A trauma alert was called ahead due to mental status change (GCS \leq 12).

At the hospital, the patient was evaluated, and CT of the head was obtained which was negative. The physicians suspected that the combativeness may have been due to the Phenergan given in the pediatrician's office. The patient was discharged after a period of observation.

It is not uncommon for paramedics to respond to a physician's office for an emergency transport. Physicians that are not familiar with the trauma transport protocols, or the state requirements to transport to a trauma center may make life a bit miserable at the scene. The decision to call their on call doctor was a good one. Let the physicians talk on the phone while the medics do the right thing. The reason that the private physician's wishes were not honored is quite straightforward. Once the trauma system is activated, Chapter 395, Florida Statutes, governs the process that determines that a trauma alert shall be transported to a trauma center. The requests of a private physician may not override the provisions of the Hillsborough's state-approved Uniform Trauma Transport Protocol.

Vignette #2

A 30 year old male was involved in an altercation with gang members in the parking lot of his apartment complex. He was stabbed in the LLQ of the abdomen and his face. His assailants ran off when some cars approached; one passer by called 911 from his car phone. A "B" deployment resulted in an engine company and a BLS unit being dispatched. The engine was the first on the scene to evaluate this patient. The patient described the weapon that was used in the assault: a 4 inch blade. The engine crew found the facial wound still oozing blood, but there was no active bleeding seen at the abdominal site. VS: HR 84 RR 16 BP 150/76 GCS 15. The engine company dressed his wounds, and determined that the patient could go by BLS. As the care of the patient was being transferred to BLS, the engine captain and the EMT disagreed over the appropriateness of this transport request. The BLS crew felt that this should be a trauma alert and that the patient should only go to a trauma center. The captain refused to believe that a stab wound to the abdomen counted as a trauma alert, arguing that only penetrating injuries to the thoracic area applied. The BLS crew allowed themselves to be intimidated and transported emergency to the nearest non-trauma center and did not call a trauma alert.

Yes, a stab wound to the abdomen is a trauma alert. How do you judge the depth of a knife wound to the abdomen in the field? You can't. It can't be done in the ER without either exploring the wound operatively, or studying with contrasted CT. Why do you chart trauma alert criteria and then transfer care to a BLS company, not call a trauma alert, and transport to a non-trauma center? Luckily, the patient did well.

Vignette #3

An elderly female was the restrained driver of a automobile that was T-boned on the passenger side with major interior compartment intrusion. The patient was wearing a lap belt and the air bag deployed on impact. When fire rescue arrived to evaluate the patient, her chest was tender and she was having difficulty breathing. She denied LOC. She also c/o pain to right hip and buttocks. They found her A&O X 3 with VS HR 110 RR 18 BP 147/80, lungs clear and equal bilaterally, moving all extremities well. Their brief neuro check was non-focal. The medics immobilized her and transported to a non-trauma center. A second set of VS en route were essentially unchanged.

The non-trauma center ED evaluation revealed all spine x-rays to be negative. The CXR showed multiple rib fractures and there was a small pneumothorax. A CT chest showed a 10-15% anterior pneumo with small hemothorax. The CT abdomen showed a mesenteric mass 13cm x 6cm thought to be hematoma with free fluid (blood) in the pelvis. The patient was reported to have brief episodes of hypotension in the ER, which responded to fluids and pRBCs.

A surgeon admitted the patient to the non-trauma center and managed her non-operatively, with thoracotomy tube and observation. A complaint was filed by the ER that this patient should have been trauma alerted and taken to a trauma center.

A 71 yo patient with chest wall bruising - does this meet trauma alert criteria? No - this patient had normal vital signs, normal mental status, and met no other trauma alert

criteria.

The receiving facility (surgeon) was uncomfortable with this patient. Does she meet trauma transfer criteria?

Yes. This patient could have legitimately been transferred to a trauma center. The mesenteric hematoma would have been a good reason for a trauma surgeon to observe the patient.

Vignette #4

Two restrained passengers from same MVA were taken by difference ambulances (one ALS, one BLS) to the same non-trauma center.

Patient #1 was a 42 year old female complaining of left shoulder and back pain, though her exam was relatively unremarkable. VS 132/70 HR 96 RR 24 GCS 15.

Patient #2 was a 71 year old female, who had an avulsion/laceration of the face and a bloody nose. VS 180/80 HR 90 RR 20 GCS 15.

Both patients were discharged from the ER after x-rays and suturing. The ED doctor complained that because these patients needed a lot of x-rays, they should not have been brought to a non-trauma center.

How many x-rays are too many? Are number of x-rays needed a trauma alert criteria? (Thought you might need some comic relief.)

Vignette #5

A 51 year old female tripped over a chair while doing housecleaning and hit her back when she fell to the ground. When the ALS engine company arrived, she told them she had pain in her right hip, and numbness and tingling to right lower leg. She had not hit her head and had no LOC. They assessed her VS and found: HR 72 BP 120/p. No other vital signs were recorded. The GCS was 14 (one off on motor).

The engine crew transferred care of this patient to BLS who were impressed with the patient's change in sensory status. They fully immobilized her on a backboard,

called trauma alert and transported to a trauma center, due to loss of sensation (suspicion of spinal cord injury).

The patient was worked up with CT and MRI in the ED. All x-rays come back negative. She was able to ambulate at discharge from ER, feeling much better.

Does this patient with back pain from trauma, and tingling and weakness in the lower extremities meet trauma alert criteria? Yes, the patient did meet TA criteria. The engine company did recognize some sensory deficit. Even if the patient was not trauma alerted, she should have been taken to a trauma center.

Vignette #6

A 60 year old male was cleaning his yard up after a storm. He placed a bunch of shrubbery in a ditch, doused it with gasoline, and ignited his the shrubbery and himself. He managed to drive himself to a fire station where the crew placed some dressings on his extremities and then told him that he could continue on to the hospital by private car. The patient was triaged at the non-trauma center ED with pain, redness and circumferential blistering of both legs. Both legs sustained 1st and 2nd degree circumferential burns from the thighs to the ankles, 20% BSA, meeting trauma alert criteria. The appropriate initial stabilization of the burns was provided (sterile dressings, IV fluids, MS04) and an interfacility transfer was arranged. He was admitted to the burn unit for 13 days.

The station crew denied recall of this patient. All walk-ins seen should be recorded in the station log and any treatment rendered should be documented on a run report. Obviously circumferential burns to 20% of total body surface area meets trauma alert criteria.

We are pleased to announce that Dr. Wayne Cruse, Head of the Regional Burn Center at TGH will be attending our regular TAC meetings from now on and will be a welcome addition to our discussions of burns and electrical injuries.

Vignette #7

An engine company was the first to evaluate a 20 year old male with a large open laceration to the left side of his neck. He was found sitting on the front porch of a house in Ybor City. He told the crew his injury was caused by falling onto a plexiglass table. His initial VS were BP 120/60 P 120. The RR wasn't documented. There was no active bleeding. They applied dry gauze and kling and then transferred care over to BLS, who arrived after the wound was dressed.

The BLS crew proceeded to do their own assessment. Their initial set of VS were BP 120/60, P 110 RR 16. The patient story and told them that he had cut himself on a metal kitchen counter. They did not unwrap the dressing that the engine company had applied, but all negative. The patient was admitted for 23 hour observation and sutured in the ED.

Discussion: When is a neck laceration a trauma alert? Is it necessary to undress and re-dress a neck laceration? Did this patient meet trauma alert criteria? Should this be BLS or ALS transport? The patient did not meet physiological criteria for a trauma alert. Neck injuries are difficult to assess in the field. If there is no obvious bleeding or airway compromise, in a patient who is awake and alert with normal vital signs, transport to a trauma center is recommended, but it is not necessary to call a trauma alert. The wound does not have to be re-dressed if there is no active bleeding or stridor or other complications, as was the situation in this case. The patient was not a trauma alert but should have been transported by ALS, an IV started and airway equipment kept handy during transport.

Trauma Agency Web Site

The message bears repeating. The Trauma Agency's web site is a rich repository of resources for the both the lay person and healthcare professional seeking to learn more about the organization of trauma care locally and statewide. There are many documents available for

downloading, such as Hillsborough's Trauma Plan or the Uniform Trauma Transport Protocol, Hillsborough's Interfacility Trauma Transfer Guidelines, numerous state trauma system reports, trauma statutes affecting the hospitals and EMS, maps, trauma center approval standards, cost analyses for trauma center operation, links to professional organizations, a calendar of upcoming meetings, events and training, back issues of newsletters, upcoming trauma symposium info. We suggest you bookmark the site and check it periodically. The address is:

<http://www.hillsboroughcounty.org/publicsafety/trauma/home.html>

UTTP revision forthcoming

Change 7 to Hillsborough's Uniform Trauma Transport Protocol is in the works. Two substantive changes being proposed to the Bureau of EMS for approval include indications for calling a helicopter and the replacement of Criteria for Consideration of Transfer from the Resources for Optimal Care of the Injured Patient, 1999, Committee on Trauma, American College of Surgeons with Hillsborough County Trauma Agency Interfacility Trauma Transfer Guidelines, and Hillsborough County Trauma Agency's Inventory and Hospital's Specialty Call. Other changes incorporate the names of new EMS transport services, changes in agency and hospital names and changes in medical direction.

Interfacility Trauma Transfer Guidelines

Hillsborough's Interfacility Trauma Transfer Guidelines have been in effect since January 2002. Color posters for hanging in emergency departments and pocket-size guides for physicians and staff will be distributed to the hospitals in the near future. A problem with a vendor significantly postponed the process. We regret this delay. A similar likeness to the poster can be viewed on-line at:

<http://www.hillsboroughcounty.org/publicsafety/trauma/transferguide.html>

INSIDE THIS ISSUE

Countywide Hospital Bypass Update 1
Internet-based Bypass Activation / Notification and Reporting System Coming 1
Hillsborough County Enhanced Disease Surveillance System 3
Update on the Tampa Bay Metropolitan Medical Response System (MMRS) 4
Digital Radiology System at St. Joseph's 5
Florida's Trauma Registry Moves Forward . . 6
New Critical Intervention Devices Debut . . . 7
Drawing blood for the Medical Examiner . . . 8
Sixth Annual Trauma Symposium 8
News from St. Joseph's Hospital 9
Who's Else is New? 9
News from Tampa General Hospital 10
South Bay Hospital ED Expansion 11
Trauma Vignettes 12
Trauma Agency web site 15
UTTP revision forthcoming 15
Interfacility Trauma Transfer Guidelines . . . 15

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:

Barbara K. Uzenoff, RN, MPH
Trauma Coordinator
Hillsborough County Trauma Agency
Emergency Operations Center
2711 E. Hanna Avenue
Tampa, Florida, 33610

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.

Visit our web site at:
<http://www.hillsboroughcounty.org/publicsafety/trauma/home.html>

HILLSBOROUGH COUNTY
Board of County Commissioners



Hillsborough County
Florida

Hillsborough County Trauma Agency
Emergency Operations Center
2711 E. Hanna Avenue
Tampa FL 33610
1253

Address label