Loss of Control in an Emergency

Another imaginary emergency run on Beaver Island

By Joe Moore

There are many times that circumstances can mess with your head. If you live on Beaver Island, and you have experienced this, you will understand right away. We as EMS providers encounter this loss of control several times per year simply due to the weather. We can't fly a patient off the island due to the weather. It's either foggy, or it's a white out with snow, or it's huge thunderstorm and not safe to fly, or there's freezing rain, etc. Weather is our primary issue, but this particular situation caused us to wonder what we had done wrong, and how we could prevent this from happening again. This situation was before we had an FAA certified air ambulance aircraft, owned by Island Airways, and licensed by Beaver Island EMS.

I'm not talking about losing control by getting sick on an emergency. That's happened many times. The first time while giving mouth to mouth rescue breathing to a heart attack victim before any equipment arrived. When the patient vomited, so did I. The good thing was that he started breathing again. The bad thing was that I was still retching when the ambulance arrived. But, I'm not talking about this kind of loss of control.

Here we go.

"Beaver Island EMS, respond to the xxxxxxxx residence for a fifty year old male. Unknown problem. Brother states that he is just not acting right?"

"Central 97 echo 4 is in route," I radioed after the second page. You can't get your radio traffic in between the two pages. They are given one right after another.

Echo 4 is headed down the east side of Beaver Island going lights and sirens, but knowing the possibility of coming upon a vehicle coming the opposite way in the center of the road, keeping the speed down to something that allows control of the vehicle. The plume of dust being kicked up on the gravel road makes the look in the rearview mirror worthless. Then after passing the Welke Airport and the Beaver Island Golf Course, there are some pretty nasty curves as well. I enter the first curve and come upon a dust cloud of another vehicle in front of me. I have to slow down to a crawl because I can't see the vehicle in the dust cloud. I reach over to change the sound of the siren from the normal to the "whoop, whoop, whoop" and, almost instantly, I come upon the vehicle in front of me that is pulled over to the side of the road. They heard the siren and pulled over to let me get by.

I continue down the east side of the island on the East Side Road, and meet another vehicle coming from the opposite direction. I can see him and he can see me. That is, until we pass each other when we are blinded by the dust plume rising from our passing. Once again, I need to slow down because I

can't see anything in front of me. Luckily, I'm only a couple of curves and about a half mile from the residence.

"Central, Dispatch, 97 Alpha 2," I hear over the radio.

"97 Alpha 2, go ahead with your traffic," Central replies.

"Alpha 2 is in route to the xxxxxx residence down East Side Drive," is the response.

I pick up the microphone from the dash board, and notify the ambulance of the serious dust issue, and get told, "I'm aware of that issue. I live down there," Terry's voice responds. This is a different voice from the one that called the ambulance in service. The driver must have his/her hands full doing the driving and the other EMT up front in the passenger seat must have the radio microphone in his hand.

"Alpha 2, I have passed two vehicles south of Welke Airport, and the dust plume blinded me. I'll be continuing…..Break, break, break, Cental Dispatch, 97 echo 4 is on scene," I replied. Now being on scene on the East Side of Beaver Island means you have seen a mail box on the side of the road that is close in number to the one that you have been dispatched to. Then, all of a sudden, you encounter a mailbox that is numbered higher than the one that you are headed to. "Central Dispatch, 97 echo four. Correction, I have passed the address. Break, break, break, Echo 4 to Alpha 2. Do you know which driveway goes in to the residence, Terry."

"Echo 4, Alpha 2. If you have arrived at an address higher, you need to turn around and head back. The residence must be on the old East Side Road, which is quite a ways back off the road. If you don't find it, let us know and we'll take the higher number driveway. Copy?'

"Echo 4 is clear on this," I respond as I pull onto a two track driveway headed back off the East Side Road. Normally, someone would be out at the end of the driveway, or, in the dark, someone would have some lights on or something to help us arrive in a reasonable period of time.

I come upon another two track that goes left and right somewhat perpendicular to the two track I'm on. Which way do I turn? Since the numbers on the mailboxes were getting larger as I went south, and since the number on the driveway was smaller than the address I'm headed to, I turn right and go south, and sure enough two houses down I see a porch light on, and it's daylight, so this suggests that I'm at the right place. The light is on a small building, I take to be a guest residence for the bigger more expensive house that is on the beach. I pull up and park the echo car, shutting off the siren, but leaving the lights going to help the ambulance see me when they come down the driveway. I pick up the microphone and notify them that I took the correct driveway, climb out, open the back end of the echo car, grab the jump kit, and go up to knock on the door.

The door opens as I prepare to knock, and the person answering the door, says, "He's in here," pointing to a small room off the rather messy living room. The patient, who weigh twice what I weigh, and I'm quite a bit overweight, is sitting on a couch just inside the small bedroom. The first thing that I notice is the very raw smell of urine emanating from the patient and from a bucket next to the couch. My brain

goes into overdrive. I ask the 400+ pound patient, “Can I do an assessment on you? Do I have permission to touch you?”

The patient does not respond, but his eyes gets big. I can see the urine stained underwear and blanket that is under him. The next thing noticed was the droop on the left side of his face. I start the assessment. “Can you close your eyes for me?” (He does.) “Can you open them for me?” He does. “Please close them again.” (He does.) “Where am I touching you?” (He does not respond.) I touch on the other arm. “Where am I touching you?” He raises the arm touched. I repeat the same thing with both legs. He does not feel me touching him on the same side as his arm that he couldn’t feel. “Can you repeat what I say to you? You can’t teach an old dog new tricks.” He tries to smile, with only one side of his face moving. I lift both of his arms up, and I say,”Keep your arms out in front of you.” The one arm falls immediately after I move the hand that is holding them. I am thoroughly convince that there is neurological problem, more than likely a stroke.

I ask the man who had opened the door for me, “How long has thing been going on? I can see that he has soiled himself. When was the last time he was able to get up to go to the bathroom?”

“He wouldn’t let me call 911. He wouldn’t let me get him some help. He kept shaking his head NO, and he wouldn’t talk to me. He must be really mad at me because he always talks to me. What’s wrong with him? Oh, my God, what is wrong with him?” the other man blurted out.

“97 Alpha 2 is on scene,” I hear on the radio on my hip. “Bring in the cot right away. We want to transport right way, “ is my response.

The patient is getting really worked up after hearing me say that. He is shaking his head, fiercely glaring at me with only one side of his face, making a very strange sight. His live-in friend says, “See what I mean? He won’t go anywhere? He is just stubbornly refusing to go or do anything.”

I begin speaking calmly, but forcefully, “You friend here has had a stroke, or so it appears. He needs to be evaluated in a hospital, and then treated if it hasn’t been too long since the onset of symptoms. How long ago did the symptoms begin?”

“It started last night. He hasn’t gotten off the couch all night. He could stand up last night and pee in the bucket. This morning, he couldn’t get up to pee, so he peed himself. He wouldn’t let me call anyone for help. He quit talking this morning, but he surely could bitch me out last night. He called me every name in the book. I went to bed about two this morning, and when I woke up, he was still sitting there, had peed himself, and wasn’t talking. I finally called for help just before you guys got here, a little before lunch time. I called the medical center and they must have called 911,” the patient’s friend stated.

“So, how much does your friend weigh? I’m guessing somewhere around four hundred pounds. Is that in the ball park?” I asked.

“You’re probably pretty close. We don’t have a scale in the house, and we threw all of them out at our home in Flint. He was too heavy for all of them. Most of them quit at 300 pounds. He weighs more

than that. I know I couldn't get him up this morning to pee in the bucket," his friend responded. "I just couldn't get him to a standing position."

Just as the last statement was made, the medical center provider on call walked in the door. So we had another person to try to get the patient to give us permission to get him to the hospital. After about ten more minutes of the medical center provider assessment and communication with the patient. She said calmly but firmly, "Fred, you need to have these people take you to the hospital. You are in serious condition. You've had a stroke, and the sooner you get to the hospital, the sooner you will be able to get better."

I don't know what she had said differently, or the way she said it, but instead of shaking his head no, he nodded his head yes. Sharon, the provider from the medical center turned to me and said, "Okay, you've got your agreement, so now you'll have to get some help and get him off this couch and onto your cot. Is Terry here? You and Terry will probably be able to get him up."

"I'd guess we are going to need a stair chair just to get him out of the bedroom and over to the place where the cot is," I spoke out loud. "Terry, I'm going to need your help in here. Can we get the stair chair in here, please?"

"Here it comes," Terry said. "How do you want to do this? Shall we try to get him standing up on his good leg, and then pivot him to sit in the chair? Do you think that will work"

"Let's give it a try," I said. Speaking to the patient, I said, "Okay, Fred, here is what we are going to do. We want you to help us however you can. We are going to try to get you to stand up. Are you ready? Here we go." The first time we tried to get him up it just simply didn't work, but we got him back sitting on the couch closer to edge of the couch. He did not have any pants on with a belt that we could use for leverage. All of a sudden, Sharon made a suggestion that made complete sense.

"He's sitting on a blanket. I'll get one side of the blanket, and Ben can get the other side. Then when you try to lift him and get him to stand up, we'll have the lower half of his body and can help keep him in an upright position," Sharon said.

"Okay, here we go. I'll count to three and on three we'll all move and try to get him in a standing position," I said. "One, two, THREEEE!" And the patient was helped to a standing position. "Quickly, Terry, get that stair chair right here" and I pointed to the position for the chair. Terry and I have been working together for quite a few years, and he knew exactly how and what to do with the chair. As we worked as a team, four of us helping the patient, and Terry placing the stair chair, we finally got the patient in a sitting position on the stair chair.

"How are we going to secure him to the chair?" Terry asked. "The belts aren't long enough."

"Grab some triangle bandages, and we'll make this work, " I said. "We only have to keep him in the chair for about thirty feet." Using the straps tied with triangle bandages we extended their length and crossed the straps to make an "X" across the patient's chest. We used triangle bandages to tie the patient's hands together. We didn't want the patient to get hurt when we moved him. We lifted the

patient's legs and got them on the shelf for that purpose, and then tied them onto the stair chair using triangle bandages.

"Okay, Terry, you take one side, and I'll take the other, and we'll tip the chair back and move him out of the bedroom," I said. "We'll have to be careful to only tip it far enough to get the chair to move." We were successful, after jockeying the chair around a couple of times to get the patient out of the bedroom and into the living room next to the ambulance cot.

We used the same method to move the patient from the stair chair as used to get him up from the couch. The difference was that those with the blanket helped to ease him down to a sitting position on the ambulance cot as did the two holding his arms at the shoulders. The cot had a folding cot on top of it to make patient movement easier. With all four EMS persons working together the patient was positioned on the ambulance cot and strapped to not only the folding cot, but also to the ambulance cot. Once again, some additional support using triangle bandages was necessary, but it was completed quite easily. The patient cot was moved into the travel position by the four mentioned and pushed out to the ambulance and loaded into the ambulance. The first step in getting this patient to the hospital was completed, and we were headed to the township airport.

Why the township airport? At this point in our history, the local air taxi service was unable to fly an emergency patient of the island. We began the next step in the process. Central Dispatch was asked to contact an air transport service in Traverse City, NF. We are continuing on our way directly to the township airport without any plans on stopping at the medical center. The provider had seen the patient at the residence and agreed that the patient needed to be transported, and there was no further treatment that could take place at the medical center, so there was no reason to go to the medical center.

"97 Alpha 2, Central Dispatch," the radio blasts just as we turn onto the driveway of the airport.

Terry, our EMT, answered, "Go ahead Central, 97 Alpha 2 is at the Beaver Island Airport."

Central replies, "Have you out at the airport. NF's fixed wing is out on a double transfer. They will not be available for at least six hours."

"Copy that, Central, we'll check on any other possibilities, and get back to you," Terry said. "So now what are we going to do?' Terry said to me. "Should we try the Coast Guard?"

We are parked on the tarmac of township airport where we would normally wait for the responding aircraft, but we didn't have an aircraft responding at this time. I asked Terry to join me in the airport terminal building where we had access to a telephone. I asked another EMT to get another set of vital signs, and to monitor our patient. We have been involved in this emergency for a little over an hour and a half, and we don't have any transport arranged for our patient.

Inside the terminal building, I opened up the run box to look for phone numbers. Inside was a business card that I had gotten for a two engine helicopter air ambulance company out of Grand Rapids, Michigan, named AeroMed. I showed this to Terry. "Well," I said to Terry, "what do you think? Should

we give them a try? They said they had one of their helicopters in Big Rapds in the summer time. It shouldn't take them too long to get here."

Terry said, "Okay, I'll give them a call. Why don't you go back and check on the patient, and I'll give them a call to see what's up."

I went back and climbed into the back of the ambulance. "How's our patient doing?" I asked.

The EMT responded, "Vital signs are all within normal limits. Oximeter reading is good on room air. Our patient remains stable. Anything else you want me to do?"

I went through the Miami Emergency Neurological Deficit exam with our patient to see if there were any changes in his status. He still had loss of sensation and loss of movement on the left side of his body and facial droop. With him sitting at a forty-five degree angle on the folded cot, he was able to keep his airway clear although he did drool a little We kept wiping it away with a couple of 4x4's and kept suction ready in case we needed it. Obviously, he had had a stroke, and he was beyond the three hour treatment window because the symptoms had started last night.

Terry stuck his head in the side door of the ambulance and said, "The bird is in the air and should be here within forty-five minutes to an hour. We better get some copies made of our paperwork. We need a face sheet and medical history. You want me to get someone to bring us the paperwork from the medical center, or we can send someone in to get it. We might as well present ourselves in the best light possible."

"Why not? We will keep taking vital signs every fifteen minutes and keep our form nice and neat. When they get here, I'll want to be able to give them all the proper paper work and a good verbal report. I wonder how they'll contact us," I replied.

"They have my cell phone number to call us, so I'm going to stay out here. Who do you want to make the trip to town?" Terry asked.

"They can take the echo car and make the run into town. Hey, Karen, you want to make a trip back into the medical center and get us a face sheet, a medical history sheet, and a medication list, please? (She nodded yes.) We will need two copies--one for us and one for AeroMed. Also, can you pick up some water for all of us and some ice chips for our patient?" I asked.

The next forty-five minutes zipped by with providing information to the health center who forwarded this information to our medical control hospital, monitoring our patient, taking vital signs, and recording everything neatly on the several pages of our patient contact record. The water arrived, and we gave our patient a few ice chips to take care of his dry mouth. We discussed the fact that every IV that we started in the field was immediately replaced at the hospital. The discussion centered around whether our current patient needed an IV or not. The patient was stable, with very stable vital signs, no signs of shock, and no signs of any developing problems beyond the stroke. The patient was obese, and we could locate one vein easily if we needed an IV for treatment, but we chose not to use the only easily accessible vein when we did not need it, and the patient did not need it at this time.

We spent the time taking turns in the back of the ambulance and going into the terminal building for the restroom and the drinking fountain, and we used the phone in the building to do most of the calling leaving Terry's phone available for any communication with AeroMed. And pretty soon, we heard the helicopter, saw the helicopter, and watched the helicopter land about thirty or forty yards away from our ambulance.

I went out to meet the medical personnel who came off the helicopter. I gave my report to a physician's assistant, who listened, and I handed the paperwork to the paramedic, and all three of us climbed back into the ambulance. I was excited to see a two engine helicopter, and I was looking forward to transferring the patient to this AeroMed crew.

The PA took one look at the patient, told the paramedic to get a set of vitals, and stepped out the back of the ambulance. He said, "There is no way that this patient can be flown in our helicopter. He weighs too much for our cot. I'm going to call and talk to our office and see what they have to say." He stuck his head into the back of the ambulance and said to his paramedic, "When you're done there, come on back out here. We have an issue that we need to resolve."

Terry had been present at this conversation. He stated, "The patient is already on a folding cot. We can move him into your helicopter on that folding cot. Problem solved. Is there any reason we can't do that? Or we can just call the Coast Guard."

The PA said, "That's a solution, but I have to get this or any other solution cleared by my boss. It's not in our protocols, and that's the problem."

So, here we are on Beaver Island at the township airport. AeroMed has arrived and taken charge of the patient, but the patient is still in our ambulance, and our people are still monitoring the patient. We have lost control of the situation, and the person in charge of the patient doesn't know anything about transportation of a patient off of Beaver Island. Even worse, the bosses and the bosses' boss are now involved, and somebody sitting in an office somewhere with no knowledge of emergency transport off Beaver Island is going to make a decision that fits in with policies and procedures written for an urban EMS system. Those with the knowledge and information are now taken out of the loop of communication. We have lost control of our patient and his transport to the hospital.

Two and a half hours later, way beyond any period of time that would allow emergent treatment for our patient, the offices of AeroMed have come to the conclusion that was possible. If they would have just listened to us two and half hours ago, the patient would have made it to the hospital much quicker. This was the plan that they came up with one hundred fifty minutes after taking responsibility for the patient.

The PA said, "This is what I have approval to do. My office is contacting the Coast Guard to send a helicopter. We will load the patient into the USCG helicopter. I will fly with the patient to Harbor Springs. Our Aeromed helicopter will follow us to Harbor Springs. We'll go with the ambulance crew to the hospital, turn the patient over to a physician at Northern Michigan Hospital, and then return to Harbor Springs Airport. We can then return to Grand Rapids, hopefully before nightfall."

The PA's paramedic partner asked, "The patient does not have an IV. Do we start an IV?"

The PA's response was, "We are an ALS agency, and so we have to have an IV for an ALS transport even if none of our equipment goes in the Coast Guard helicopter, and even if we don't have any treatments to give. It is a requirement of our protocols. So, yes, you must at least do a saline lock."

So, after another hour that it took for a second helicopter, this one from the USCG, to arrive. BIEMS wheeled the patient out of the BIEMS ambulance, helped load the patient into the USCG helicopter, and physically turned the patient over to the PA from AeroMed, who then crawled into the USCG helicopter to sit on the metal deck. The USCG helicopter took the PA and our stroke patient to Harbor Springs Airport. The AeroMed helicopter and the AeroMed paramedic took off headed to the same place about five minutes later.

And this was the craziest, but not the longest, day of patient care for a BIEMS emergency patient on Beaver Island. This is how we lost complete control of patient transportation of this patient. Did we learn something? Absolutely! Follow our tried and true procedures of transporting a patient. Don't try to recreate the emergency transport procedures on the fly. Use what works for Beaver Island, and not what works for the office staff in a big city!