LIFEFLIGHT OF MAINE
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Address Service Requested

Dispatches is published by LifeFlight of Maine for members of the state's Emergency Medical Services community. Comments and suggestions may be directed to the Central Maine Medical Center Communications Department. Telephone:795-2475.
E-mail:cmmc@cmmc.org
For more information about LifeFlight, call toll-free 877-262-2525.

...Heather Grandmaison continued

Because of the distance, the original plan was to transport Heather the eight miles to CMMC by ground ambulance. The turning point in deciding to activate LifeFlight was the very serious condition of the patient and the prolonged extraction.

Twenty nine minutes after the initial call to LifeFlight, Heather was being treated in the CMMC Emergency Department for multiple fractures of the femur and pelvis, a cracked sternum and lacerations.

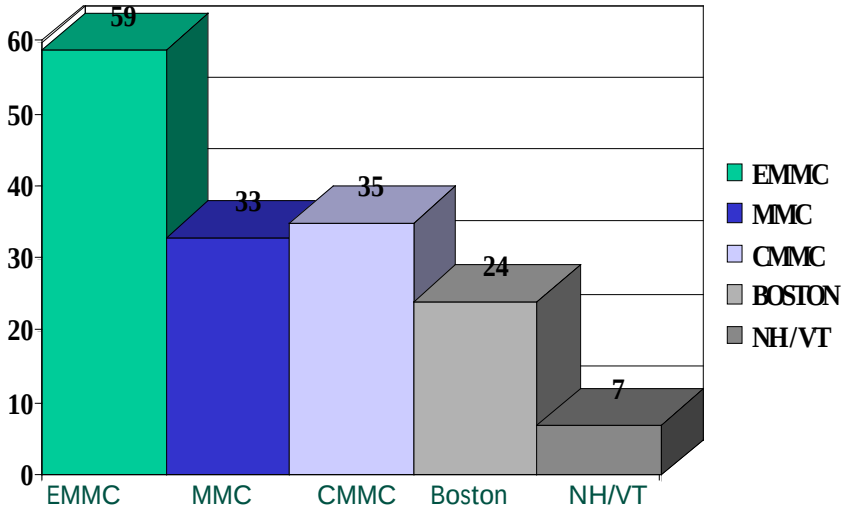
"The helicopter flight was noisy, but really smooth. No bumps along the way and the ride didn't hurt me," Heather said.

Heather is now at home and doing well. She will be a senior next year at Leavitt Area High School where she plans to be active in chorus and drama. "We are glad LifeFlight was there," said Janet Grandmaison.

LifeFlight Fast Facts

- LifeFlight has answered calls in every hour of the day. Peak activity is between 4 p.m. and 6 p.m.
- Acute surgical patients are the single largest group of chief complaints transported, followed by severe closed head injury and multi-trauma.
- LifeFlight's youngest patient was 4 days old and the oldest over 90 years!

LifeFlight Transports: Hospital destinations



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DISPATCHES

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"What she found by the pool was her unconscious four-year-old, being given mouth to mouth resuscitation by another adult whom she barely knew."

LIFEFLIGHT AIDS IN SAVING LIVES

by Jill McDonald

Imagine the scene: the day after a wedding, the bride and groom's families are gathered relaxing by a pool, some eating breakfast just inside and discussing yesterday's big event.

A flock of children is splashing joyfully in the water, under the watchful eye of several of their parents. Suddenly, one child cries out that someone is at the bottom of the pool. This was the scene Lori York remembers on the twenty-third of May, in Millinocket, when her sister-in-law ran to her urging her to come quick, something had happened to Rachel. "I knew by her voice something was really wrong," remembers Lori.

Rachel York visits with LifeFlight of Maine flight nurse John Macone and paramedic Sue Wardwell. LifeFlight's Bangor crew transported the girl from Millinocket Regional Hospital to Eastern Maine Medical Center in Bangor after she suffered a pulmonary edema in a pool accident. See accompanying story for details.

What she found by the pool was her unconscious four-year-old, being given mouth to mouth resuscitation by another adult whom she barely knew. Lori's husband, dripping wet from having dived into the pool to rescue their daughter, reassured her that the woman was an EMT and that 911 had already been called.

Later, Lori learned that Rachel had been playing with the other kids and had gotten too close to the spot where the pool bottom descended into deeper water. Rachel slipped and went under. It was only a matter of minutes before she was undergoing rescue breathing, and by the time the Millinocket Fire Department rescue personnel arrived, she was breathing on her own. Because of the serious nature of the call, four individuals from Millinocket Fire Rescue responded: Thomas Little, Paul Brown, Cathy MacArthur, and Wilbur Perry.

"I rode with her in the back of the ambulance, and when I spoke to her she would nod her head, but she wouldn't talk," her mother remembers. "I work in a hospital as a medical technologist and I knew Rachel was in trouble when she didn't respond to the pain of the IVs being put into her."

At Millinocket Regional Hospital Rachel was seen by emergency room physician assistant Timothy Canham, PAC. "Rachel was fairly stable when she arrived," remembers Canham. "She was conscious and crying. We did a chest x-ray, established IVs, and were discussing transport to Eastern Maine Medical Center, possibly by ground, when she began to decompensate. Her breathing became more shallow, she was lethargic, and had diminished lung

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MISSION STATEMENT

To provide a statewide medical helicopter service that transports critically ill and injured patients.LifeFlight will provide the highest quality of care and follow rigorous safety standards.

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LIFEFLIGHT OF MAINE

MIKE BRADY HEADS UP LEWISTON SQUAD

LifeFlight of Maine assistant lead pilot, Lewiston site manager

By Randall Dustin

LifeFlight pilot Mike Brady is a difficult person to interview. But this difficulty arises from modesty, not arrogance. As Maine's first hospital-based air medical transport system continues to evolve, Mike sees himself as part of a team that is still coalescing. He is uncomfortable with the prospect of being highlighted apart from the other LifeFlight team members.

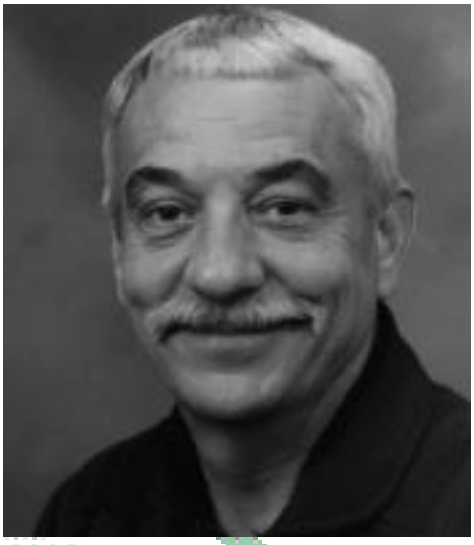
Nonetheless, if an intrepid interviewer presses on, a conversation with Mike reveals a pilot who has nearly 30 years experience "working with a pretty unusual machine." The Ohio native began flying not long after he graduated from high school. His career spans six years in the military, several years flying tours in Hawaii, and a number of lengthy stints providing oil service support in the U.S. and abroad. He began his work as an emergency medical services pilot in California in 1985.

Mike gained his first flying experience in the U.S. Army, where he completed 15 months of flight school training in Texas and Alabama. Although his three years in the Army were served during the Vietnam War, Mike says he was fortunate to be assigned to provide "air mobility support" at a military base in South Korea. A large percentage of the helicopter pilots in Vietnam did not return home, he explains.

Following his tour of duty in the Army, Mike was commissioned as a Coast Guard officer and assigned to Barbers Point, Hawaii. After three years with the Coast Guard he returned to civilian life as a tour pilot in the 50th state.

Mike's academic background includes a bachelor's degree in aeronautical science and an associate degree in aviation management from Embry-Riddle Aeronautical University in Daytona Beach, Fla. Since lifting off for the first time in 1970, he has amassed more than 7,300 flight hours in 16 different helicopter models at locations stretching from Alaska to the Gulf of Mexico to Abu Dhabi.

A soft-spoken, seemingly impassive man, Mike chuckles when asked what



it's like to be part of an initiative that has drawn such widespread public attention. "I'm a pilot. It's what I do. I was trained in a skill," he says modestly.

Mike says the opportunity to be involved in the start-up of LifeFlight of Maine appealed to him because of the "the ruralness. The vastness of the forest up here." Relocating to the area was easy. "Professional, single helicopter pilots are generally vagabonds by nature," he explains.

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sounds. The chest x-ray confirmed pulmonary edema and we quickly decided her transport better be by air."

Help From Above

LifeFlight of Maine was contacted at 9:55 a.m. "This was not a difficult decision," remembers Mission Approval Officer (MAO) Dr. Jacques LaRochelle. "Clearly, when a child of four and a half is in respiratory distress, and on artificial life support, that child needs pediatric intensive care as quickly as possible." LaRochelle points out that many smaller hospitals are equipped to handle adults in this situation, but pediatric intensive care requires more specialized equipment and personnel. LifeFlight of Maine requires all mission requests to be approved by an MAO to ensure the most appropriate use of the medical helicopter system.

The aircraft arrived at Millinocket Regional at 10:38 a.m., just as the hospital team finished intubating Rachel, bringing with it the critical care technology of the region's tertiary care center. "I could hear the helicopter coming in," Lori's voice falters. "I can remember just praying to myself, 'please save my daughter.' " Together, the LifeFlight team — pilot Howard Albecker, paramedic Sue Wardwell, and flight nurse John Macone — and the hospital emergency personnel worked to prepare Rachel for the flight to Bangor. "The LifeFlight team is very professional, very good," remarks Canham, who has had cause to call LifeFlight twice in the four months he has been working in Millinocket. "These are not pushy people. They arrive on scene and blend right into the local medical team. I'll use them again in a second if I need to."

Important Good-byes

The LifeFlight crew also helped to prepare the parents. "It felt to me like they must have children of their own, because they were so compassionate," says Lori. "When they were ready to go and I was saying good-bye, they didn't rush me. They let me do what I needed to do."

LifeFlight nurse John Macone, R.N., C.F.R.N., C.E.N., says he always encourages families to talk to their loved one, even if the patient is unconscious. "We tell them to whisper something encouraging and that even though the patient is unconscious there's a good chance they'll hear. It's important to give families that time to say what they need to say. These patients are critically ill."

At 11:15 a.m., little more than two hours after Rachel's foot had made that fateful misstep, she was in the air, her care taken over by LifeFlight's critical care team. Rachel was unconscious, having been sedated before her caregivers inserted an airway. Nurse Macone remembers feeling pretty optimistic during the flight that Rachel would recover. "She had been under water only for a short time and had received rescue breathing immediately. There had been some respiratory complications, but I was optimistic."

The Road Home

The team landed on EMMC's helipad at 11:44 a.m., and Rachel was taken directly to Pediatric Intensive Care, where her parents would spend the next two days watching her pass milestone after milestone on her way to recovery. "When they extubated Rachel on the evening of the second day she gave a little raspy cry. It was the first sound I'd heard her make and it almost made me cry," her mother remembers. "Then she reached up and pulled out her NG tube before the nurses could do it. I knew she was going to be okay."

Rachel is home with her parents and her eight-year-old brother now, and back to her busy, chatty, normal self, her mother says. "When LifeFlight took off with Rachel, I watched it. I couldn't take my eyes off it. That crew took her like she was their own. And every one of them came up to visit her in the hospital."

Lori now knows that LifeFlight of Maine would not have been here a year ago. "Looking back on it, now that I know the complications she was experiencing, I don't know if Rachel would have made it through without the helicopter."

Continued from page 3

ical crew, the assembly of medical records, imaging studies, transfer documents and the like will facilitate the transfer. Determination of the transition venue with Lifeflight is also essential. In selected circumstances, the patient may be brought via ambulance to the aircraft if the landing site is other than at the hospital itself, on interfacility missions. For scene flights, the determination of the appropriate landing zone should be based on the parameters outlined in the User's Course for prehospital care providers. For intercepts or other rendezvous between prehospital care providers and the air-medical crew, clarity must be achieved between providers in advance, with suitable timely updates if changes are required, as necessitated by weather, traffic, etc.

Be proactive, deliberate and move forward

Pilots always "stay ahead of the aircraft." Similarly, a proactive clinical and logistic thought process which keeps the provider "ahead of the patient" is of inestimable benefit in integrating the assets, and efforts of all providers and institutions in the "choreography of care." Remember that speed in one aspect of the system cannot overcome delays in another. In the last analysis, it is not the minutes we SAVE, but how we all INVEST those minutes, which will maximize the likelihood of a favorable outcome for the patient.

CONSIDERATIONS IN OPTIMIZING THE USE OF THE LIFEFLIGHT AIR-MEDICAL SYSTEM

By Norm Dinerman,M.D., F.A.C.E.P.,
Medical Director, LifeFlight of Maine

The accomplishments of Maine's new air-medical system are inspiring. Fundamentally, we are now able to tether the immense clinical resources of prehospital care providers, and the expertise and capital investment made by the hospitals of this state in a more efficient and effective manner. Core philosophical and operational principles have been reaffirmed, and new ones have emerged, which underscore our experience in the state of Maine to date. As we approach the first anniversary of the system, we felt that a review of those principles which optimize the use of the air-medical system would be helpful.

While the publicly perceived advantages of helicopter transport derive from the unique speed and access capabilities of the aircraft, it is the expertise of the medical crew that provides the physician with the clinical substantiation for its use. The ability to limit the patient's time in the highly vulnerable out-of-hospital phase of care, coupled with critical care enroute to a tertiary care institution, functionally joins the medical assets and expertise of the entire state. It is this very integration which is fundamental to generating the greatest benefit from the use of the air-medical system on behalf of selected patients. The air-medical system is but one “layer of excellence” which enables a sophisticated and ultimately, contemporary practice of medicine in our state. Clearly, each medical intervention provided by every provider from first responder to emergency medicine clinician must reflect a sophisticated approach which couples seamlessly with the next provider. The air-medical system cannot serve as a panacea, nor as a remedy for delays or therapeutic misadventures elsewhere in the system. Similarly, errors in the use or in the care of the patient by the air-medical team will nullify the efforts of those providers who have, or will, intervene on his or her behalf As health care providers, we are all inextricably joined.

Considering the following can maximize integration of health care provider efforts:

Time

To the extent that credible information substantiates the need to utilize the air-medical system, the health care provider should activate the system as soon as possible. For prehospital care providers, this may be prior to arrival at the scene in selected cases (for example, victim with an amputated leg) or as early as the very arrival at the scene and the performance of the primary survey. Patient's whose injuries (need for transport to a regional trauma center, as described in Maine EMS Trauma Triage Protocol) and circumstances (need for extrication, distance from community hospital, etc.) or need for additional resources are compelling, should activate the air-medical system either through, or with the consent of, on-line medical control. For emergency medicine clinicians, activation may precede the arrival of the patient, based on the assessment of prehospital care providers. Alternatively, upon initial identification of the patient's injuries or illness as requiring tertiary care, the air-medical system should be activated. This proactive approach allows the system to minimize the delay that would otherwise be experienced in flying to the patient. Diagnostic and therapeutic interventions can be achieved while the aircraft is enroute to the referring institution.

Dialogue

Contact of Lifeflight should be integrated with the dialogue between the referring and receiving clinicians. For referrals to Eastern Maine Medical Center, Central Maine Medical Center or Maine Medical Center, the emergency medicine clinician is able to accept the patient in transfer. If further dialogue with a consultant is needed, the emergency medicine clinician will arrange this. The emergency medicine clinician can also activate the air-medical system on behalf of the referring clinician, enabling the referring clinician to return to the bedside of the patient. If transfer to another tertiary care hospital is desired, the air-medical system should be contacted after the dialogue between referring and receiving clinicians has been accomplished.

Diagnostic and Therapeutic Interventions

Those which are required to achieve resuscitation and stabilization of the patient, or to define the need for transfer to a tertiary care institution, should be undertaken. Ideally, if the need for transfer is self-evident, only those diagnostic tests upon which action will be taken, should be accomplished. Interventions which will facilitate the stability of the patient enroute, including insertion of orogastric tubes, or endotracheal intubation, or facilitate monitoring, such as a Foley catheter, A-lines, etc., should similarly be undertaken prior to the arrival of the air-medical crew, if possible.

Documentation and Transition

Prior to the arrival of the air-med-

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Paramedic Profile

SUE WARDWELL, PARAMEDIC SINCE 1985

Critical Care Transport Coordinator, Bangor

By Jill McDonald

Sue Wardwell comes by her interest in EMS work honestly. Both her parents were volunteers with Fairfield Rescue when she was a child. Her dad worked for what is now Delta Ambulance. In 1978, when Sue was just 17 years old and still in high school, she began volunteering for Fairfield Rescue herself. Despite her young age, Sue doesn't remember ever being frightened by what she witnessed in her work. "To me it was more of a challenge. I never thought of it as scary." There were, however, difficult moments. "When you live in a small town, you know people," Sue remembers. "It's hard when a friend says to you, 'Sue, please save my mother.'"

Beginning in 1978 Sue worked her way through the levels of EMS training, becoming a paramedic, the highest level of EMS provider, in 1985. In 1981, Sue began a thirteen year run with Delta Ambulance in Waterville. That was in the days before critical care transport. "EMS crews would have to do patient transfers with really sick patients. In those days, we didn't have the sophisticated equipment on board, and we'd cross our fingers and go for broke."

In those days, Delta Ambulance ran a fixed wing aircraft service to transport patients, mostly veterans, to and from Togus. “We did five or six flights a week. I saw the value of air medical service then, but after about 10 years, volume and reimbursement for the service was decreasing and so flights tailed off.”

Since those days with Delta critical care air service has been one of her dreams. Seeing LifeFlight on the helipad gives her a wonderful sense of satisfaction. "It's an important step for EMS in Maine and for critically ill patients. It's so much safer to have the appropriate equipment and trained crew on the vehicle to care for these patients." It requires more training, and lots of extra time for the crew members, but Sue says it's worth it. Sue points to the cooperation of the hospital partners as vital to the success of the LifeFlight program.

"The relationships between the hospitals and the EMS providers is so important. The EMS providers are getting valuable ongoing training in the hospital intensive care units, so they are prepared for the needs of critical patients during flights. It truly is a team effort making up the big picture of LifeFlight. The team is great."

News

DINNER AND PARTY, CHANGED QUICKLY

Heather Grandmaison, 16, of Leeds was going out to dinner and a party with friends in the late afternoon of May 15. Her plan for an enjoyable evening soon changed drastically. The auto she was in collided with a Chevy Suburban on Route 202 in Greene. A total of eight people were involved in the accident.

“Everything started to hurt,” said Heather after the impact. By coincidence, Janet Grandmaison, her mother, drove by, recognized the car and said “Oh, my God, that's my baby in the car.”

Oliver Solmitz and Scott Latullipe of United Ambulance were the first unit on the scene. Two Turner Rescue ambulances arrived and eventually two more United Ambulances were called.

Heather and one other trapped victim were involved in a prolonged extraction conducted by Turner Rescue. Scott Latullipe of United Ambulance directed the primary triage at the scene and called a Code 11 alerting Central Maine Medical Center of the incoming trauma victims. Heather is especially grateful to Scott Latullipe. “He is caring, smart and he made me feel that everything was under control.”

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