



Transport

July / August / September 2003

Bulletin

Notes from the Chair

by Steven E. Sittig, RRT

By now you should have all received your AARC Transport Lapel Pins. I have had nothing but positive comments on the appearance of the pin. This wonderful pin not only reflects our specialty but will help us educate the public and other medical professionals about the role RTs play in the transport of patients in a growing number of programs nationwide. The lapel pin will be a great promotional item to help us recruit and retain section members as well. On behalf of the Section, I want to thank the AARC for committing to this pin project and send a special thanks to Sherry Milligan and Kris Williams at the Executive Office in Dallas for their help in ensuring the project was completed.

By the time this newsletter reaches you, the AARC International Respiratory Congress in Las Vegas will be only a short time away. I do hope you are able to attend, as the transport symposium submitted by the section was accepted for presentation. In fact, there are going to be three transport-related symposiums during the Congress. The section business meeting will be on December 8, the first day of the conference. I hope to meet all attending members and potential new members there. With your help, I also hope to be able to announce that we have reached 350 members. As I have noted many times in the past, we must reach the 350 member goal for this section to remain a stand-alone specialty section. If every member would recruit just one new member, the goal would be reached.

In early April, I was able to attend the Critical Care Transport Medical Conference (CCTMC) in Louisville, KY. Fellow section members Kathleen Adams and Tom Cahill joined me at this multidisciplinary conference hosted by the Air Medical Physicians Association, Air Surface Transport Nurse Association, and Flight

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A View from the Other Side: Our CAMTS Survey

by Thomas J. Cahill, RCP, RRT, EMT-P

As they say, turnabout is fair play. This year, our program was up for reaccreditation CAMTS, and what an experience!

Maintaining accreditation is an ongoing performance improvement process. You should be looking daily at your processes and how you can improve them to increase patient care and staff safety while still remaining competitive with the services in your area. The actual accreditation process for a program seeking accreditation takes a year or so. Documentation is key. What do they need? Only some of the basics - policies, procedures, protocols, utilization review, staffing standards schedules, safety meetings, team meetings, orientation, ongoing training, just to name a few! The surveyor and board reviewers like to see a lot of worth of data in order to prepare for the visit.

So you've completed your Program Information Form (PIF) - a 100-page self-study directly related to the Accreditation Standards - and are ready to send it off to South Carolina. What happens then? The PIF is reviewed by at least two members of the board and the site surveyor. A site visit is scheduled within 4-6 weeks after they receive the PIF.

What can you expect when the surveyor arrives? Look for a shotgun start - and that means let's take a look at your problem areas first. Then the surveyor proceeds to every aspect of your program, from health screenings to your mechanic's tools, making helpful suggestions and recommendations along the way. At the end of the survey a summary conference takes place to review the highlights (and not-so-highlights) of your program. A board member then presents the program and surveyor recommendations to the full board, which votes on the accreditation.

For now I would just like to note that we passed our recent survey with flying colors. It truly was a learning experience from both ends. Typically, from start to finish, it takes CAMTS approximately 210 hours to complete the comprehensive evaluation of your program. This requires a lot of hard work and dedication by the board and surveyors. But they are all devoted to fulfilling the mission of CAMTS, which is safety in our community.

How can one or two people review so much in so little time? That's a topic for the next Bulletin. Look for an article on the qualifications needed to apply to be a site surveyor and the training surveyors undergo in your October-November-December issue. ♦

Is Ground Ambulance Safer Than Air Transport?

by Steven E. Sittig, RRT

The transport request comes in at 3:30 p.m. for a six-year-old boy who is having seizures. The trip is only 45 miles away and the weather is not a factor as you leave the hospital. The ambulance driver asks you, "How fast do you want to get there?" You know the small facility you are going to is extremely nervous about having such a sick child in their emergency room, so you tell the medics, "We need to get there fast." As you leave the hospital you and the transport nurse are thinking of the protocols you will need to follow as you speed down the road. Traffic safety doesn't enter your head.

You arrive at the referral hospital and find the child is now seizing almost constantly despite previous efforts. In order to control these seizures you must administer even higher levels of seizure medications, and the child will need to be intubated. As the transport

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Section Connection

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IS GROUND AMBULANCE SAFER THAN AIR TRANSPORT?

you select your intubation equipment while the nurse begins to draw up the medications. The intubation goes without a hitch and the child's seizures have now subsided. You begin to package the patient for transport as your nurse colleague calls back to medical control to report the patient's status and your estimated arrival time. As you load into the ambulance, the medic, seeing the intubated child, asks whether you want to go back the same way, with lights and siren. Knowing you will most likely be encountering some rush hour traffic you almost automatically agree to the red lights and siren.

As you are securing equipment and the patient before you leave, you realize the securing mount for your ventilator is not working. Being a member of the inventive lot that respiratory therapists are, you place it under a seatbelt strap on the stretcher and pull it tight.

You are now nearly home and traffic on the road is building. You feel the driver hit the brakes hard a couple of times and swerve once when cars fail to pay attention to the red lights and siren. Your transport nurse colleague is now unbelted to give additional sedation to the patient, and you hear the medics scream "HOLD ON!" As you are going through an intersection a car broadsides the ambulance. Now everything is in motion, including your partner. As the ambulance is knocked over on its side, you see the nurse bounce around like a pinball and at one point land on the patient. Then suddenly your ambulance is hit from behind by another car. The last thing you see is the ventilator flying off the stretcher toward your head.

In this hypothetical situation it would not be unrealistic to assume everyone in the back of the ambulance may have been killed or seriously injured, along with the medics up front and any occupants in the cars. However, this scenario is not meant to frighten. It is intended to make you realize what a dangerous environment the ambulance can be.

One of the great lecturers I heard at the Critical Care Transport Medical Conference this year was Dr. Nadine Levick, MPH. Dr. Levick is a leading ambulance-crash researcher and director of pediatric emergency medical services at New York's Harlem Hospital Center. She also serves as an assistant professor at Columbia University. In her lecture she noted that ambulance transport in the United States has a high crash injury rate per mile traveled. What's more, the ambulance is exempt from many U.S. vehicle safety performance standards. However, Dr. Levick went on to note that ambulance hazards are "predictable and preventable." Many of the problems lie in design and how people operate in the back of these rigs. I think it would be safe to say that all of us who do transport have been unbelted in the back of a moving ambulance at one time or another. The comparatively larger interior space of the ground rig versus the aircraft makes getting up and moving about the interior easier and seemingly without major hazards.

After hearing Dr. Levine's lecture, everyone present realized this is not the case. It is unfortunate that ground ambulances are not really designed with safety in mind, especially for the medical crew and the patient. Several European countries are now designing ambulances that provide caregivers with access to everything they need without removing their seatbelts. This concept may one day make its way to the United States, but until then, we, as care providers, need to be diligent about safety and securing everything in the ambulance.

Anytime an air medical craft crashes it is front page news and posted on e-mail lists such as Flight Web. I cannot remember the last time I heard an ambulance accident reported on the six o'clock news. Those of us who do transport know there are risks, but we do it for the critically ill patients we can help. However, we need to be as safe as we can to protect our patients and ourselves. Some simple rules to follow are:

1. Have the ambulance driver drive safely and observe traffic laws. Red lights and siren are not a guaranteed cloak of safety.
2. Tightly secure everything in the ambulance, including monitoring equipment, transport bags, the patient, and especially yourself.

Since many RTs who do transport are involved in the care of newborns and children, one item in Dr. Levine's talk especially hit home - namely, assuming it is safe to strap car seats on the ambulance stretcher. Those of us who work at tertiary centers most likely see local ambulance services bring in young children secured in such a fashion. During her lecture, Dr. Levine showed a crash test in which a toddler mannequin was secured in a car seat in the manner described above. The footage was chilling, as the car seat and mannequin were violently tossed about.

The bottom line: safety is everyone's business. So as you are dispatched on your next ground transport, please take the time to insure all is safe and secure. ♦

Do You Have HEICS?

by Brad Carman, RRT, senior respiratory therapist, transport team member, Shriners Hospital for Children, Cincinnati, OH, and Ohio Society for Respiratory Care Transport/Disaster Relief Chair

With so many countries in a state of unrest and the United States experiencing frequent Code Orange alerts, state and local preparedness is the key to having the best response possible in any given disaster situation. The Hospital Emergency Incident Command System (HEICS), which was developed by the San Mateo County Emergency Medical Services Agency with funding by the California Emergency Medical Service Authority, provides just that. HEICS can be integrated into your hospital disaster response plan and has been designed to follow National Fire Protection Association (NFPA) guidelines for disaster management. Following NFPA guidelines allows each hospital to be consistent with government agencies in a disaster response situation. HEICS also covers all Joint Commission on Accreditation of Healthcare Organization requirements for disaster preparedness and management.

With HEICS, the management chain is predictable. Each position has set functions and responsibilities. The organizational chart can be customized for a flexible response to specific emergencies. This system also provides improved documentation during an emergency. The HEICS forms cover everything from Activity Logs and Volunteer Staff Registration/Credentialing to Patient Tracking Sheet and Emergency Incident Message. Common language is used to facilitate outside assistance from government agencies. Response checklists are prioritized to ensure safety and expedite tasks. HEICS has facilitated cost effective emergency planning within many health care corporations that have implemented the system.

I attended the HEICS training course in April 2003 and found the course to be very informative and enlightening. The system includes an organizational chart outlining the positions and the chain of command. The hierarchy usually follows this sequence: the emergency incident commander, a section chief, a director, the supervisor, the unit leader, and finally, an officer. All of the activated positions receive a Job Action Sheet that can be customized to suit the facility's needs, an identification vest for each position, and forms pertinent to the section and positions. Two components of the Job Action Sheet that should not be changed are the universal titles and the mission statements. These components allow emergency responders from a variety of organizations to communicate quickly and clearly with other subscribers to the Incident Command System-style of management. Only those positions or functions that are needed should be activated. Most disasters will require far fewer than the 49 listed on the chart. HEICS should be collapsed or combined from the bottom of the organizational chart upward. This will make the implementation of the hospital's disaster plan as "user friendly" as possible. In times of crisis, the simpler a task can be made, the better its chances of being completed.

The training included a two-and-a-half-hour tabletop exercise simulating a disaster. The exercise is used not only to educate staff members about HEICS, but also to demonstrate the importance of communication among coworkers. According to the plan, participants should focus on the proper interrelationships between job assignments, not the exactness of a particular response to a simulated problem.

It is very important for all of us to become familiar with HEICS, because it is quickly becoming the national standard for disaster preparedness in the health care industry. The system adds structure and guidance to an otherwise stressful and chaotic situation. I would encourage all of you to visit the following list of HEICS sites and to check with your state hospital association for HEICS training.

The HEICS manual, template, and all associated forms are offered free of charge to hospitals. Its program includes lesson plans and help with the installation of the HEICS. Most of the costs associated with the adoption of the plan will be in training and exercising the new plan. ♦

HEICS Sites:

- www.emsa.ca.gov/Dms2/heics3.htm
- www.heics.com/download.htm
- www.ohanet.org/terrorism_preparedness/heics/
- www.heics.net
- <http://www.hazmatforhealthcare.org/>
- <http://www.ess-cert.org/> ♦

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NOTES FROM THE CHAIR

Paramedics Association. During a session break, Kathleen and I were speaking with Scott DeBoer, who is an RN and an excellent lecturer. Scott travels all around the nation speaking to nurses, therapists, and medics on a variety of topics related to pediatrics and transport. I wish I could give you an accurate description of his lecture style, but let's just say he entertains and educates. If you ever get a chance to hear him speak, I highly recommend you do so. If you are looking for a quality speaker for a regional or state conference let me know and I'll forward his contact information to you.

As Kathleen and I spoke with Scott he asked us a very interesting question. He said that when he travels around the country one question frequently asked by the RTs who attend his lectures is, "Is there a national association for transport respiratory therapists?" Kathleen told him there was such a group - namely the AARC Transport Section - and that I was the current chair. I gave Scott my contact information and have since received contact information in return for several RTs looking for more information. This startling fact just goes to show we need to actively promote this specialty section to everyone involved or interested in transport. And our best tool is you, the transport RT at the local level, who is aware of local programs that use RTs. If you know of any local transport programs that may not know about the section, either contact them directly with information on how to join or send me contact information to me and I will contact them.

Until next time, may all your transports end safely for you and your patients. ♦

Program Focus: Crouse Hospital Neonatal Transport Team

by Steven E. Sittig, RRT

The Crouse Hospital Neonatal Transport Team at Crouse Hospital in Syracuse, NY, consists of four respiratory therapists and two nurses. Criteria for team membership include at least three years experience in the NICU, the Neonatal Resuscitation Program credential, living within 30 minutes of the hospital, and attaining the Neonatal-Pediatric Specialty credential within one year of joining the team.

The team was started in 1985 and currently performs approximately 300 transports each year. About 90% of transports are via ground ambulance, with the other 10% either the sheriff or state police helicopter, both of which have brand new Bell 207s. The team formerly performed transports via fixed-wing aircraft. Team members receive a stipend hourly rate for being on call and at least four hours' pay when called in, which is generally overtime since there are no other paramedics who do only transport. They also receive a stipend for each transport.

Team members are trained in endotracheal intubation, umbilical artery and umbilical vein catheterization, administration of all necessary drugs, institution of peripheral IV lines, needle thoracotomy, and chest tube insertion (although no one has yet performed this last skill on a patient). ♦