Transport Bulletin

July/August '99

Notes from the Chair

by Kathleen Adams RCP, RRT

For those of you who attended the Critical Care Transport Medicine Conference (CCTMC), I hope you enjoyed it and were able to have some fun both on board ship and in Nassau. This is the first time the CCTMC has used the cruise conference concept. The conference directors received some good remarks and good suggestions. The cruise may be offered again in the future, but for next year, plan on Las Vegas. If you can't make it to Las Vegas for the AARC International Congress this year, or if you are just a Las Vegas junkie, you can get some "City of Lights" time in at the CCTMC in April of 2000.

Another conference on the horizon is the 1999 Air Medical Transport Conference (AMTC) in Nashville, TN, November 1-3. I am currently negotiating for time and space so that we can hold a meeting for the RTs who attend. Place and time will hopefully be posted in the conference materials. I hope to see you at the meeting.

As previously mentioned, the AARC Congress is scheduled for Las Vegas December 13-16. This is always a fun conference, as well as an educational one. Our section has scheduled some very interesting lecture topics and speakers. I hope many of you can attend, and if you do, please plan to stay for the section meeting. (See your Congress program for exact meeting time.)

We have several other items on our section agenda. I have made first contact with the committee chair who oversees the development of position statements for the AARC. Your section leadership is looking at the need for, and potential development of, a position statement regarding the practice of respiratory care during transport. Although there are existing statements that can be applied to this area, the AARC does not currently have a statement specific to our area of specialization.

We are also looking into a statement regarding iNO on transport. I would like to hear from any of you who have comments, ideas, or suggestions regarding either of these items. These suggestions can be passed on via the section listserve on AARC Online (www.aarc.org) or to me directly by phone or email (numbers/addresses listed on page two).

With that, I will let you start enjoying the rest of the *Bulletin*. As always, may your roads be smooth and your landings soft. ■

NSC Update in the Works

by Jerry Focht, RRT

In mid-May, I represented the AARC at the Air Medical Crew/ National Standard Curriculum (NSC) Task Analysis and Evaluation Conference in Falls Church, VA. Star Mountain Incorporated sponsored the conference for the National Highway Traffic Safety Administration. Twenty-two representatives were present.

There have been many changes in the industry since 1988 when the NSC was first developed. Our task was to update the curriculum to 1999 standards.

The first hot potato was the idea of developing an advanced curriculum for registered nurses and paramedics. I respectfully requested that the group include RTs in this category. I

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"NSC Update" continued from page 1

pointed out that 50-plus teams in the AAMS directory claim to use RTs in some fashion and that the CAMTS standards include RTs as "critical care" providers. All present supported my position. The consensus was to make the curriculum generic in composition and leave it to each individual program to best modify the curriculum to meet its team configuration.

Another idea was to consider making the NSC a critical care document. However, attendees felt that this meeting was not the proper place to make that decision. The curriculum was named the Advanced NSC.

We also decided to make the curriculum specific to the differences that exist in the air medical environment. In other words, we don't want to reinvent the wheel on medical care protocols, but we do want to address issues specific to the air medical environment, such as air physiology and crew dress, to name a couple. We would provide detailed references and a source guide for programs. Programs could use the latter to tailor the medical care they provide. The guide would also include a list of organizations that programs could contact for more information.

The revised standards will be posted for comment on Star Mountain's web site at www.starmountain.com.

I believe it was very beneficial for me to represent the AARC at this conference. If you have any questions, please contact me at (800) 572-3210 ext. 2, or focht@arias.net. ■

Sutter Children's Center of Sutter Medical Center Sacramento

by David A. Blackney RCP, RRT

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Sutter Children's Center transport services began transporting neonatal patients in 1982 and pediatric patients in 1991. The program, which serves over 23 counties in Northern California, bringing in thousands of neonatal and pediatric patients, has been staffed by respiratory therapists and registered nurses since its conception.

Two modes of transportation are utilized by our team depending on the location, acuity, and seasonal access –ground and fixed wing (C-421 Golden Eagle). A helicopter will soon be added to the list. Any calls over a 120-mile radius would be considered flight transportation. However, we have flown patients in from as far away as Seattle, Denver, and San Salvador (using a Lear jet).

Before a therapist can obtain a position on the transport team, he must have at least two years experience in our Special Care Nursery and Special Care Pediatrics. Therapists must also maintain certifications in both units, the Neonatal Resuscitation Program, Pediatric Advance Life Support, and Basic Life Support. In addition to their initial training, team members must also be trained as medical flight crew members.

Respiratory therapists on the team are trained in an advanced life support program developed by our own physician staff. On transport, RTs intubate, ventilate with conventional and high frequency jet ventilation, and deliver all aspects of oxygen and aerosol care. They also assist RNs in UAC/UVC placement, chest tube insertion, intravenous line placement and set-up, and interosseous line placement. Utilization of nitric oxide on transport is currently under development. We are looking at using iNO solo and/or with HFJV, as is done for our pre-ECMO patients. ■

Pictured, left to right, are Gail Mullick, Barbara Piringer, Jerry Czerbasij, Kristen Anderson, John Mancilla, and Kip Checkley.

CAMTS Representative Needed

Jerry Focht, our long-time representative to the CAMTS Board of Directors, will soon be vacating that position. We are currently looking for a replacement. If anyone is interested in representing the AARC three times a year at the CAMTS board meetings, please contact Jerry at (800) 572-3210 ext. 2, or focht@arias.net. The AARC and CAMTS provide funding for this position. ■

CAMTS Accredited Transport Services

The following list contains all of the programs that were CAMTS accredited as of 4/1/98.
** = Reaccredited/RW= Rotorwing/FW= Fixed Wing/G= Ground Critical Care*

AeroCare — Lubbock, TX	RW/FW	Conemaugh Med Star — Johnstown, PA	RW	Life Flight — Toledo, OH	
*Air 1 — Tyler, TX	RW	Critical Air Medicine — San Diego, CA	RW/FW	LIFEFLITE Medical Air Transport — Mesa, AZ	FW
*Air Evac Services, Inc. — Phoenix, AZ	RW/FW	Eagle Rescue of Arizona — Phoenix, AZ	RW	*LifeGuard— Albuquerque, NM	RW/FW
Air Med Team — Modesto, CA	RW	*EastCare — Greenville, NC	RW/G	Life Watch— Wichita, KS	
AirMed — Salt Lake City, UT		Flight Care — Saginaw, MI		Loyola LIFESTAR— Maywood, CO	RW
AIR TREK — Punta Gorda, FL	FW	*Flight for Life — Denver, CO	RW/FW	+Mayo One — Rochester, MN	RW/FW
*AirEvac for Tulsa — Tulsa, OK	RW/G	Flight For Life — Milwaukee, WI	RW	Med Arizona, Inc. — Show Low, AZ	FW
AirLife of Greeley — Greeley, CO	RW	Gallup Med Flight — Gallup, NM	FW	+Med Center Air — Charlotte, NC	RW/FW/G
Airlift Northwest — Seattle, WA	RW/FW	Guardian Air Transport — Flagstaff, AZ	FW	Med Flight Air — Albuquerque, NM	FW
Allegheny Life Flight — Pittsburgh, PA	RW/FW	HealthNet — State of West Virginia		MedJET International— Birmingham, AL	FW
Angel Flight — Little Rock, AR	RW	* INOVA AIRCARE — Falls Church, VA	RW	*Medi-Flight — Modesto, CA	RW
* + Butterworth AeroMed — Grand Rapids, MI	RW	*INTENSIVE AIR — Sioux Falls, SD	RW/FW	Medical Express International, Inc. — Show Low, AZ	FW
* CareFlight — Dayton, OH	RW	Life Air Rescue — Shreveport, LA	RW	Mercy Air Services, Inc. — Fontana, CA	RW
CAREFLIGHT — Lexington, KY	RW	LifeFlight IHC — Salt Lake City, UT	RW/FW/G	* +Metro Life Flight — Cleveland, OH	RW/FW/G
*CareFlite Dallas — Dallas, TX	RW/FW	*LifeFlight MeritCare— Fargo, ND	RW/FW	MidWest MEDFLIGHT — Ypsilanti, MI	RW

ative American Air Ambulance, Inc.
Iesa, AZ RW/FW

orth Flight, Inc. —
raverse City, MI RW/FW

orthWest MedStar —
pokane, WA RW/FW

Presbyterian Air —
lbuquerque, NM FW

EACH Mediplane —
anta Rosa, CA RW/FW

REACT —
ockford, IL RW/G

an Juan Air Care —
armington, NM RW/FW

Shriners Burns Institute
Transport Team —
Cincinnati, OH FW

St. Joseph's Health Systems —
Tampa, FL RW/FW

St. Mary's Air Life—
Grand Junction, CO RW/FW

STARS —
Edmonton, Alberta, Canada RW

STAT MedEvac —
Pittsburgh, PA RW/FW

Survival Flight —
Ann Arbor, MI RW/FW/G

Texas AirLife —
San Antonio, TX RW

Topeka Air Ambulance, Inc. —
Topeka, KS RW

*UCDMC Life Flight —
Sacramento, CA RW

*UMC Air Care —
Tucson, AZ RW/FW

University Air Care —
Cincinnati, OH RW

University MedEvac —
Allentown, PA RW

Washington MedSTAR —
Washington DC RW

West Michigan AirCare —
Kalamazoo, MI RW/FW/G

+ = "**Commendation"**

Flight Fixes

Here are some actual maintenance omplaints submitted by US Air orce pilots, along with the replies ıey received from the maintenance ·ews. These "Squawks" are problem stings that pilots generally leave for ıaintenance crews to fix before next ight.

roblem: Left inside main tire almost needs replacement.
olution: Almost replaced left inside main tire.

roblem: Test flight OK, except autoland very rough.
olution: Autoland not installed on this aircraft.

roblem: #2 Propeller seeping prop fluid.
olution: #2 Propeller seepage normal - #1, #3, and #4 propellers lack normal seepage.

Problem: Something loose in cockpit.
Solution: Something tightened in cockpit.

Problem: Evidence of leak on right main landing gear.
Solution: Evidence removed.

Problem: DME volume unbelievably loud.
Solution: Volume set to more believable level.

Problem: Dead bugs on windshield.
Solution: Live bugs on order.

Problem: Autopilot in altitude hold mode produces a 200 fpm descent.
Solution: Cannot reproduce problem on ground.

Problem: IFF inoperative.
Solution: IFF always inoperative in OFF mode.

Problem: Friction locks cause throttle levers to stick.
Solution: That's what they're there for.

Problem: Number three engine missing.
Solution: Engine found on right wing after brief search.

Problem: Aircraft handles funny.
Solution: Aircraft warned to straighten up, "fly right," and be serious.

Problem: Target Radar hums.
Solution: Reprogrammed Target Radar with the lyrics.

Transport Section Classifieds

The following position is now vailable –

Internet Coordinator: Responsible ır monitoring section and AARC eb site and bulletin boards, alerting section chair of postings that require an answer, and posting answers as appropriate. Would monitor other web sites that may be of interest to the section membership or benefit from an AARC link. Develop new ideas for the section web site. For information or to apply contact Kathleen Adams, chair, Transport Section, AARC at (909) 824-0800 ext. 43809 or e-mail: kadams@ccmail.llumc.edu ■

FYI . . .

***Thumbs Up* to Delta Air Lines**

When Delta Air Lines decided to equip all 584 of its aircraft with automatic external defibrillators and enhanced emergency medical kits by June 30, six months ahead of schedule, it didn't know it would be saving the life of one of its own employees. But that's what happened shortly after one aircraft received the equipment in late May.

A 40-year-old Salt Lake City-based Delta flight attendant collapsed shortly after the flight departed from Salt Lake City. Trained Delta flight attendants readied the onboard defibrillator for use, while two nurses onboard as passengers came forward to assist in reviving the flight attendant's heart rate. The defibrillator was used to deliver two shocks to the flight attendant's heart while the flight immediately returned to Salt Lake City. Once on the ground, the flight attendant was rushed to the hospital. She is now recovering from the cardiac arrest, thanks to the new onboard medical equipment and the quick reaction of the crew and the nurses.

Leave the helmet on

Over the past 20 years, the annual incidence of hockey-related spinal injuries has increased markedly, and the most common injury is to the cervical spine. Now researchers from the University of Minnesota in Minneapolis have found that these injuries can be minimized if the helmets of downed players are not removed.

"Removal of the helmet increases the extension of the cervical spine, which may cause or exacerbate an existing injury," say the investigators. "Our study indicates that this lordosis, or backward extension, greatly increases and puts the player at greater risk for a more serious injury."

In the study, ten adult male volunteers, ages 18 to 28, with no previous history of cervical spine injuries, were fitted with appropriately size ice hockey helmets and shoulde pads. All subjects were immobilize in a supine position to a standar spine backboard to secure the head i a neutral position. Images of eac volunteer's spine were taken wit computerized tomography scou scans with the subjects wearing n protective equipment, wearing a he met and shoulder pads, and wearin shoulder pads and no helmet.

When the helmet was removed an the volunteer was wearing onl shoulder pads, a significant increas in backward extension was seen. Th extension was not evident when th volunteer was wearing both a helme and shoulder pads. These findings ar consistent with research done in foo ball players, which led to guideline on football helmet removal in 199(In hockey players, however, th extension occurs in an area of th spine where the majority of cervica spine injuries occur. (America Orthopaedic Society for Sport Medicine) ■

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