



Transport

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Notes from the Chair

by Jerry Focht, RRT

By the time you receive this *Bulletin*, the year 2000 will almost be over. But as I write this column in late October, I have just returned from the AARC International Congress in Cincinnati and the Air Medical Transport Conference (AMTC) in Salt Lake City. An important aspect of the chair's job is to gather ideas for presentations at the 2001 conferences. We need to submit our ideas for the 2001 AMTC in Orlando, FL, by December 15. Ideas for the 2001 AARC International Congress in San Antonio, TX, are due by December 29. A call for presentations has been posted on the section listserv. If you know of an interesting presenter or presentation, please post it on the listserv or contact me directly at the addresses/numbers listed on page two.

At the International Congress, the Transport Section sponsored four interesting and well-attended presentations by four flight respiratory therapists from across the country. Kie Shelly, RRT, from Cincinnati, addressed the topic, "Transport Care Scenarios: Why is My Baby Blue?" Thomas Cahill, RRT, presented a lecture on "Pediatric Burn Transport: How Do You Do That?" Mark Washam, RRT, also from Cincinnati, delivered a talk entitled, "Warp Speed Scotty: The Future of Documentation during Transport." I closed out the session with a presentation on "Training for Transport: Preparing for the 21st Century."

Following the presentations, section mem-

bers gathered for the Transport Section business meeting. Margaret Traband, MED, RRT, AARC president-elect, was in attendance in an effort to learn more about our section. Among other business, we congratulated Kathleen Adams, RRT, for being selected as our 2000 Specialty Practitioner of the Year. She is very deserving of this award for her past and continued support of transport respiratory therapists.

At the AMTC in Salt Lake City, I attended the Alliance Workgroup's first official meeting. Of utmost concern was the progress of the Safety Summit that was held in Dallas in April. We are working to make sure that the Alliance Workgroup is included in the five industry safety initiatives that are currently underway.

We also had a small meeting of RTs from across the country. The continuing themes of how to protect our positions as flight RTs and how to position ourselves as critical team members in the medical transport industry were discussed. We all felt that becoming involved in as many areas of the medical transport industry as possible and continuing to work on projects to promote the RT in transport were essential to these goals. I believe we are on the right track, but we need more help and more members to reach our full potential. Please consider getting actively involved in your section and/or recruiting your colleagues to join. ■

Notes from the Editor

by Steven E. Sittig, RRT

As I sit down to write this edition of my Notes, I am amazed that the year is nearly over. It doesn't seem all that long ago that the specter of Y2K loomed over almost every aspect of our lives. Sort of like the old adage goes, "Time flies when you're having fun." But if your program or hospital has been as busy as we have been here, it is more like, "time flies because you are too busy to look at your watch!"

I hope everyone had a good fall and found time to get away for a little relaxation. I'm sure those of you who attended the AARC Congress in Cincinnati had an educational and entertaining experience. If any of you

heard any interesting equipment-related or other presentations pertaining to transport, I would enjoy hearing from you. We might be able to share what you learned through an article in the *Bulletin*. Those of us who were unable to attend — myself included — would certainly appreciate the information.

I have received several interesting articles as a result of my "call for articles" posted on our section listserv. There are definitely some exciting things going on out there, and it is important to let people know about them.

Included this issue is a very interesting

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article from Aaron Lund about his program's experience with transports involving ventricular assist devices. I thought doing a transport with a balloon pump was enough of a technical challenge! We also have an editorial from Diane Randall about the need for everyone in the respiratory care department to understand

that transport duties are an important facet of the department and the institution. Diane brings up the excellent point that even though not everyone does transport, we, as a profession, should support our coworkers in this role.

I know I sound like a broken record — or maybe I should say a CD player without anti-skip capabilities — but I really would enjoy

hearing from you about ideas for articles or helping you do a Program Focus article on your program. As both Aaron and Diane can attest, contributing to this *Bulletin* is not a difficult process! You can contact me anytime at my e-mail address, Sittig.Steven@mayo.edu.

Until next time, fly safe, and I hope all your transports go well. ■

Specialty Practitioner of the Year: Kathleen Adams, RRT

Respiratory therapists who get involved in medical transport would be the first to agree that they are a unique breed often misunderstood by their peers, both in and out of respira-

tory therapy. Thanks to this year's Specialty Practitioner of the Year, however, that latter characteristic is slowly but surely fading away. During her tenure as section chair in the late '90s and beyond, Kathleen Adams, RRT, has worked tirelessly to promote the role of the transport RT to other groups in the industry while at the same time increasing their visibility within the AARC. Those efforts recently culminated in the formation of the Alliance for Critical Care Transport, a coalition of industry organizations — including the AARC — that is dedicated to supporting and enhancing the important role that transport and transport personnel play in our health care system.

Kathleen, who currently serves as transport team coordinator in the department of respiratory care at Loma Linda University Medical Center & Children's Hospital in Loma Linda, CA, believes the Transport Section holds the key to greater awareness of transport RTs inside the profession and out. "Respiratory therapists on transport are out there doing a very tough job . . . it is important for therapists in this unique area of specialty to stand up and be counted, and that is done by being a member of the section." ■



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In My Opinion: Changes in Latitude, Changes in Attitude

by Diane Randall, RRT, transport therapist, A.I. duPont Hospital for Children, Wilmington, DE

Like the words to the song suggest, by looking at something from a different perspective, you might see it in a different light. While the following is intended for therapists, the general idea may help others, too.

Last April, I attended the CCTM conference in Las Vegas. I met some very interesting individuals who are on transport teams nationwide. As usually happens at these get-togethers, we were able to share thoughts and experiences. Several of us, including some transport nurses and RTs who are based out of emergency rooms or intensive care units, discovered that some of the problems that we thought were "local" seem to be much more universal. See if the following sounds familiar:

Your department has a therapist assigned to the transport team. Because of staffing, the transport therapist also carries a hospital assignment. Budgets are tight, so "downtime" is frowned upon. Everyone in the RT department knows that the therapist is assigned on transport, and they all pray for the same thing — that someone will unplug the transport phone. They know that if it rings, they will have to absorb the transport therapist's hospital assignment. But, of course, the phone always does ring, usually at the most inconve-

nient moment for *everyone*, and a metamorphosis begins. The people who were just laughing and joking with the transport therapist at report change now have an uneasy edge to their voices —

"When the going gets tough, transport goes out."

"Just what I need, my assignment *and* yours, too!"

"Oh great . . . not only are you giving me your work, you're going out to bring back more!"

"How much did you pay that ER doc to call at the beginning of your shift instead of the end of it?"

"How come you're always the one who gets to fly?"

Get the picture? Most of us got involved in transports because we enjoy it. It's different, it can be exciting, and you have to think on your feet. *And the patients, the hospitals, and the departments need someone to do it!* Transport personnel don't get involved in transport just so they can dump their assignments on their coworkers. But getting those coworkers to believe that can be a difficult task, and it can

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make just trying to do your job pretty uncomfortable and frustrating.

Maybe if everyone involved tried to shift their approach to the situation — their “latitude,” so to speak — they might have a different “attitude.” Look at it this way — if the transport team didn’t “bring in more business,” some people wouldn’t have jobs. No one controls when the transport phone will ring. But when it does, response time is very important. If response time starts becoming a

problem, the “customer” may look elsewhere.

Of course, that doesn’t mean coworker don’t have any point at all when they complain about taking on the transport RT’s assignment. Proper planning for this eventuality may be lacking. For example, does your department have a plan for how the transport therapist’s hospital assignment will be handled if he or she is called out? Is this assignment given to only one other therapist or can it be shared by several?

And transport RTs themselves can play a critical role in fostering greater understanding

as well. If the transport therapist immediately starts an assignment at the beginning of a shift or helps others to get things done *just in case* a call should come in, that might show that the transport therapist is indeed a team player. In addition, if more than one therapist on a particular shift does transport, and some are lacking in either critical runs or flight time, offering to switch assignments to “spread the wealth” may be appreciated by all.

So the next time that phone rings, take a step to the side and see if a change of latitude would put things in a new perspective. ■

Transport of the VAD Patient

by Aaron Lund, RRT, NREMT-I, flight respiratory therapist, StarCare V, Lincoln, NE

Transport of the high-risk cardiac patient is a feat that the StarCare V flight team performs on a regular basis. Whether it is a patient with an acute MI on heparin and nitroglycerin drips, or a patient in complete cardiogenic shock requiring intra-aortic balloon pump (IABP) and inotropic therapy, the StarCare V flight team lifts off within minutes of receiving a call. However, on April 10, 2000, a flight request came into our dispatch center that required special planning even for us. The patient was a 45-year-old male at a referring medical facility who required a continuous flow bi-ventricular assist device (Bi-VAD) to maintain his failing heart, a piece of equipment that StarCare V, or very few other programs throughout the country, have transported regularly.

The patient presented to the referring facility two days prior to transfer with an acute MI and in cardiogenic shock. Emergently, the patient was taken to the cardiac catheterization lab and brought to the operating room. He underwent cardiac bypass surgery without incident, but physicians were unable to wean him from the heart-lung bypass machine. Due to this, they elected to place the patient on continuous flow Bi-VAD support, a device similar to that of the heart-lung bypass machine. This equipment would allow his failing heart time to recover. Post-operatively, the patient was transferred to the cardiovascular intensive care unit for further management.

Two days later, the medical team determined that the patient would need further management at a regional heart transplant facility and might ultimately need heart transplantation. BryanLGH Medical Center East in Lincoln, NE, was chosen to provide further cardiac management, and the StarCare V flight team was called upon to provide transport. After careful planning it was determined that the StarCare V fixed-wing aircraft would provide the best option for transporting the patient. The perfusion department at BryanLGH Medical Center offered their service and expertise during the flight to assist with the Bi-VAD.

At 1540, the StarCare V flight team

arrived at the patient’s bedside. Initial assessment revealed a patient with an open chest cavity and retractors in place. Four cannulas (each about 2 feet in length) were protruding from his chest wall and attached to two separate VAD machines, with an IABP inserted into his femoral artery providing pulsatile flow to his heart. Both a Swan Ganz catheter and pacer wires were present. The patient remained intubated, paralyzed, and sedated. IV medication drips included dopamine, epinephrine, levophed, cardizem, insulin, and heparin. The StarCare V flight team prepared the patient for transport and departed the referring medical facility at 1630. The referring medical facility’s perfusionist accompanied the flight team to assist with the management of the Bi-VAD equipment.

Throughout the transport, the entire team had to ensure that the chest cannulas would not receive any form of tension; thus the transferring of the patient from the ground ambulance to the aircraft needed to be accomplished with great precision. With the exception of an enormous amount of bleeding, the patient assessment remained unchanged during transport. In flight, the patient was transfused with 6 units of packed red blood cells in order to maintain adequate flow rates on the Bi-VAD pumps. At 1910 the StarCare V team arrived at the BryanLGH Medical Center East cardiovascular intensive care unit, where care was transferred to the ICU staff and waiting cardiovascular surgeons.

Exactly one month after the Bi-VAD transfer, another request came in to transfer a patient requiring an LVAD (left ventricular assist device) support. Although the circumstances were similar, this patient was utilizing a different brand of VAD equipment, which required additional planning prior to departure to assure a smooth transition of the patient. Accompanying the patient would be a member of the BryanLGH Medical Center East perfusion department, in addition to the primary StarCare V flight team. The patient was successfully transported by our fixed-wing aircraft and received heart transplantation within 24 hours of arrival to BryanLGH Medical Center East.

Transport Bulletin

The Transport Community: NFPA

Editor's Note: The Transport Community is a regular feature of the Bulletin that takes a closer look at some of the other organizations in our industry. This issue we feature the National Flight Paramedics Association.

The NFPA is an organization of paramedics

who are involved in the air medical transport industry. Most of the organization's members actively fly as flight paramedics but some are paramedics involved in managerial or administrative positions with flight programs. All active members of the group are paramedics involved in the air medical transport industry, but membership provisions also exist for those outside the industry who are interested in the field.

The primary purpose of the NFPA is to serve as an advocate for flight paramedics within the

air medical transport and EMS environments. The association accomplishes this goal by participating in a variety of industry-related committees, meetings, and educational conferences. The association also provides educational opportunities for its members and others, and has authored a number of position statements outlining the organization's stand on various issues of concern.

For more information about the NFPA, visit their web site at <http://www.nfpa.rotor.com/>. ■

FYI . . .

Study reveals lower mortality rates in children treated at pediatric trauma centers

According to a study completed by trauma teams at the Children's Hospital of Pittsburgh and Children's Hospital of Philadelphia, children 16 and younger who sustain severe injuries following blunt or penetrating trauma have a better overall outcome when treated in a pediatric trauma center than in an adult trauma center.

The study, "Impact of Pediatric Trauma Centers on Mortality in a Statewide System," was published in a recent issue of the *Journal of Trauma*. The data were collected through a retrospective analysis of 13,351 injured children between 1993 and 1997 by the Pennsylvania Trauma Systems Foundation, which is the governing body responsible for the accreditation of all trauma centers in the state.

According to the study's lead author, Henri Ford, MD, "Children have special needs that are best met in a children's hospital (with a full complement of pediatric services) that is committed to the care of injured children." Dr. Ford is the director of the Benedum Pediatric Trauma Center at Children's Hospital of Pittsburgh.

In Pennsylvania there are four types of trauma centers: Level I Pediatric Trauma Centers (PTC), Level I Adult Trauma Centers (ATC I), Level I Adult Trauma Centers with Added Qualifications in Pediatrics (ATC AQ) and Level II Adult Trauma Centers (ATC II). There are many differences between the various types of trauma centers with regard to their ability to treat injured children.

For instance, to be designated a PTC, a children's hospital must have a full complement of pediatric surgical specialties, including pediatric general surgery, neurosurgery, orthopedic surgery, and cardiac surgery, as well as pediatric intensivists and anesthesiologists, available at all times. In contrast, to be designated an ATC AQ, the main requirement is a single pediatric general surgeon on call. Other pediatric surgical specialists are not required.

Mortality in children with head, liver, or spleen injuries was considerably lower at PTCs when compared to any of the ATCs, according to the data review. The mortality rate for children with liver injuries treated at any ATC was more than twice that of children treated at a PTC.

The study revealed that:

- PTCs treated 5,189 children and had a 3.6% mortality rate.
- ATC AOs treated 3,636 children and had a 4.3% mortality rate.
- Level I ATC treated 1,207 and had an 8% mortality rate.
- Level II ATC treated 3,319 and had a 4.7% mortality rate.

Studies support use of automated external defibrillators in public places

Two studies published in the October issue of the *New England Journal of Medicine* examined the use of automated external defibrillators in public places for the emergency treatment of cardiac arrest victims.

In the first study, defibrillators were placed in casinos in Nevada and Mississippi, and security guards were trained in their use. The devices were used in 105 patients with cardiac arrest due to ventricular fibrillation. A total of 56 patients (53%) survived to hospital discharge. Among the 90 patients whose collapse was witnessed, the survival rate was 74% when the interval between collapse and the first shock was three minutes or less and 49% when the interval was longer.

In the second study, a U.S. airline equipped its aircraft with automated external defibrillators. Over two years, the devices were applied to 200 patients by flight attendants trained in their use. Thirteen of the 14 patients who had ventricular fibrillation had successful defibrillation with the first shock (defibrillation was withheld in one patient at the family's request), and 40% survived to hospital discharge.

Resource kit aims to upgrade pediatric emergency care

In an effort to provide medical professionals with the resources they need to deliver state-of-the-art pediatric emergency care, representatives from more than 19 government, national, and professional organizations recently released a comprehensive Resource Kit designed to bring organizations, communities, and states into compliance with accepted standards for pediatric emergency care. Available in CD-ROM format, the Kit contains more than 2,000 pages of critical information on pediatric injury and illness prevention, treatment, and rehabilitation. Included in the package are:

- A collection of protocols, training courses, guidelines, and procedures that address illness and injury prevention, patient care training and safety, equipment guidelines, medical direction, and public policy.
- A reference guide of additional resources and where to obtain them.
- Contact information for organizations in the emergency medical services for children (EMSC) community that are committed to strategic partnership building.

The Resource Kit was produced as part of a three-year national educational campaign to help reduce pediatric disability and death from injury and illness. The next phase of the campaign will focus on outreach to parents, caregivers, and children. Emphasis will be on methods to prevent and prepare for pediatric medical emergencies, such as identifying illness warning signs, choosing the best hospitals for pediatric emergencies, and guidelines for treating ill or injured children.

The Kit, which is currently being distributed to more than 5,000 emergency care decision-makers throughout the nation, is available free of charge at www.ems-c.org. (EMSC) ■

AARC Wants to Know Your Top Five Areas of Concern

The AARC is currently seeking input from section members regarding the top five areas of concern unique to our specialty area. Please mail, email, or fax your top five concerns

related specifically to the specialty (not to the AARC or the practice of respiratory care in general) to: Kelli Hagen, 11030 Ables Lane, Dallas, TX 75229, email: hagen@aarc.org,

FAX (972) 484-2720 or (972) 484-6010. The Association will utilize our input in determining priorities for the coming year. ■