NOTES FROM THE CHAIR  
by Kay Lockhart, RRT

I have received many calls over the last few months from RCPs who are concerned about the issue of paramedics and interfacility transport of the ventilated patient. I encourage each hospital with a transport team, as well as those individuals who are simply interested in optimizing patient care, to become involved with their state EMS systems. Petition the EMS office to include a Neonatal Network Subcommittee. Get involved with meetings that deal with issues concerning children. Attend meetings concerning pre-hospital transports and review state guidelines for scene calls. Specifically, find out who can do scene calls in your state. Petition the officers of these sub-committees to put rules in place that include RCPs. Involve transport team medical directors in this quest.

The State of Florida has successfully drafted rules and regulations that monitor personnel involved in neonatal transports. These regulations state who can do these transports and how many hours these individuals need to have in their work specialty before they can perform transports. For example, RCPs must have 2,000 hours in the NICU. This is the minimum requirement to perform neonatal transports under state guidelines for all practitioners. RNs must also meet a minimum requirement for ICU hours. Since most paramedics would have difficulty obtaining these required hours, these regulations secure a place for RCPs on the team. But establishing RCPs in EMS takes time and perseverance. Start now.

In other news, I am happy to report that our section chair-elect, Kathleen Adams, and I recently submitted proposals for the upcoming 1997 AARC Convention in New Orleans. The Transport Section submitted six lecture proposals that came from ideas that members suggested at the section business meeting in San Diego.

We are also working to increase communication among section members through the development of a new homepage on the Internet devoted especially to members of our section. The AARC Transport Section Homepage is currently in the finishing stages and the AARC executive office is busy putting together all the details governing access, etc. Look for it in March.

Lastly, in an effort to obtain national recognition for RCPs involved in transport, AARC President Kerry George and I have put together a letter to the Association of Air Medical Services (AAMS) in which the AARC is expressing an interest in becoming a member of the AAMS coalition. We feel that in order to further the RCP’s progress in the transport arena we need to become a part of AAMS. I will keep you updated on our progress.

Visit AARC on the Internet—
http://www.aarc.org

“I’LL TAKE TRANSPORT GEOGRAPHY FOR $100, ALEX”  
by John Framsted

John Framsted is a transport RCP for Mayo One in Rochester, MN.

Alex: “And the answer is Kuwait City, Kuwait; Muscat, Oman; Genoa, Italy.”

John: “What are three faraway places the Mayo One flight team has flown?”

There are 12 therapists on the Mayo One fixed wing flight team who are engaged in transporting patients to and from the Mayo Clinic in Rochester, MN, and as each of them will tell you, the job requires being prepared for just about anything. The challenges are great enough on short transports within the state or U.S.—but consider going on the really l-o-n-g flights, such as the ones mentioned above. Three of our flight team members—Craig Lamphere, Lyle Klaassen, and Pete Smith—were involved in these very calls. I would like to share their experiences and insights with you.

Craig is our lead therapist and was responsible for getting us started in our overseas adventures. It all began when we received a call to pick up a patient from a boating accident in Kuwait City, Kuwait. The team, which also consisted of a physician and a nurse, left at 2030 that night in a Hawker that needed to stop every four hours to refuel. Craig and company left Rochester International, flew to Newfoundland, Ireland, Greece, and finally to Kuwait City, arriving about 0130 local time.

When they got to the hospital, they found that the patient had been extubated and was looking pretty tired. Because of this, the team ended up staying for two days to assess if the patient was stable enough for transport. During the two day waiting time, Craig made notes in preparation for future flights. Some of these notes included packing extra clothes and a swim suit. (You have to plan for the worst, like sunny days, laying pool side and good food!!)

From the government chauffeured car that was provided for the team, Craig saw some of the damage from the Gulf War and was driven for visits to check on the patient. The team did not have to re-intubate and the patient was able to make the trip on a nasal cannula and non-rebreather mask. The patient recovered in Rochester and was able to take a commercial flight home.

Lyle Klaassen’s international adventure also took place in the Hawker, this time to Oman via Newfoundland, Ireland, Amsterdam, and Cairo. The pilots had a 12-hour layover in Amsterdam for rest, but not the rest of the crew. They took in the sights and then slept on the plane.

They arrived in Oman about 1600 and went for their first visit with the patient. He had been in a car accident which included a fatality. In the end, the patient was not flown out. The hospital did, however, contract for three or four days of services from us before Lyle flew back home on a commercial flight. During his stay Lyle got to demonstrate his technique for good pulmonary hygiene.
and take in some of the sights from his chauffeured car. He said that Muscat was very clean and had some beautiful sights but no night life, and our dollar was worth about $.33 at that time. Chicken and French fries were the best things on the menu. His list for future flights included more clothes, a Walkman, and a laptop.

Pete Smith’s trip was in the same plane and took the same route (Newfoundland, Ireland) but ended up in Genoa, Italy. Getting to the patient, however, required a two-hour ride in a Fiat ambulance with a crazy driver. The patient was in a six-to-eight-bed hospital in an outlying area, and the staff was not very receptive to having the patient leave. The Propack monitor that the team brought with them seemed to be the most modern piece of equipment there. Pete brought along an LP-6 vent for use on the trip back to the plane but ended up needing a third adapter, which he didn’t have with him, to make it work. So he bagged the patient for the two-hour trip back to the plane. (Just another mild workout for him.)

The group reported that the food was good but they had no time for tours, and at 8,000 feet elevation, everyone was feeling the need for oxygen. Pete’s best memory was of landing in Italy and watching the sun set over the Mediterranean Sea. (I’m sure, of course, that his thoughts were of all of us back in Rochester getting up to start another day in the ICU.)

Once in the plane Pete placed the patient on the LP-6, double-checked the level of the liquid oxygen system, then sat back for what he hoped would be an uneventful trip home. As it turned out, that was not to be. While in-flight the plane started to fill with smoke. Not to worry—they diverted to Iceland and fixed the problem during a two-hour layover. Then it was on to Rochester via Newfoundland and Bangor, ME. Now that was a trip, and we were all really glad Pete was the one who went.

Surviving trips like these requires taking the good with the bad and learning from both. Here are just some of the comments that tell it like it is—

- “Great experience, I’d go back on a minute’s notice!”
- “The noise of the plane would pound you for 20 hours.”
- “The food was great and they treated us really well.”
- “I stayed up with the patient for 20 hours, then crashed when I got home.”
- “You should have seen the sun setting over the Mediterranean.”

I hope you enjoyed hearing about some of our adventures. We will have more trips in the future to report on, so until another time, remember to make out your lists of things to take and do. (Personally, after writing this article, I’m sending for my passport tomorrow!)

McKennon Hospital CAREFLIGHT
Program Focus
by Brian Pruss, RRT

Brian Pruss was our section’s 1996 Specialty Practitioner of the Year.

McKennon Hospital is located in Sioux Falls, SD. We are a 429-bed tertiary care hospital offering the following services: critical care medicine, trauma center, level III intensive care nursery, nationally recognized women’s center, regional burn center, bone marrow and kidney transplant services, rehabilitation services, cardiology services, and hyperbaric oxygen medicine.

Our transport service, CAREFLIGHT, has been in operation since 1986 and was the state’s first medical helicopter service. We currently fly a Bell 222UT helicopter, and in 1995, we added a King Air 200 fixed wing. CAREFLIGHT covers a four state area, plus international flights, and completes approximately 650 flights annually. The primary CAREFLIGHT crew consists of flight RNs and paramedics, with specialty crew members consisting of RRTs, OB RNs, neonatal nurse practitioners, and neonatologists.

The respiratory care department has been involved in transport as a specialty team member for over three years. We are involved in fixed wing, rotor wing, and ground transports. The patient population that we transport includes acute trauma, high risk maternal and neonatal, critical pediatric, and adults. Patients requiring the assistance of an intra-aortic balloon pump and those undergoing hospital to hospital transfers also receive our services. We have a dedicated staff of 14 RRTs who possess training in BLS-CPR (providers or instructors), NALS, PALS, ACLS, critical care medicine, hemodynamics, neonatology, pediatrics, and flight physiology.

A Rose By Any Other Name: CAAMS Becomes CAMTS
by Jerry Focht, RRT

Jerry Focht is a member of the flight program at Northwest Medstar and the AARC’s representative to CAMTS.

In order to appropriately reflect its expanded mission to accredit ground as well as air transport services, the Commission on Accreditation of Air Medical Systems board of directors voted to change the name of the organization at their January meeting. CAAMS will now be known as the “Commission on Accreditation of Medical Transport Systems” or CAMTS. The organization is currently nearing completion of the ground interfacility standards, along with a revision of all of the standards.

A record 11 accreditation decisions were made at the October board meeting, which was held in conjunction with the Air Medical Transport Conference in Fort Worth, TX. Five programs received full accreditation and four programs were re-accredited. (I am proud to say that my program was one of them.)

At the January board meeting in Naples, FL, four programs received full accreditation and one program was re-accredited. If you have any questions about the CAMTS process, please feel free to call me at (800) 422-2440 ext. 2.

CAMTS Program Update

Editor’s Note: The following list contains all of the programs that were CAMTS accredited as of January 13. If your program has met CAMTS since that time we would like to honor you as well. Please contact me at the address/numbers listed on the back page of this issue and I’ll add your program to the list.

- CareFlight — Dayton, OH
- INOVA AIRCARE — Falls Church, Virginia
- CareFlite Dallas — Dallas, Texas
- West Michigan AirCare — Kalamazoo, Michigan
- CAREFLIGHT — Lexington, Kentucky
- St. Joseph’s Health Systems — Tampa, Florida
- Butterworth AeroMed — Grand Rapids, Michigan
**RESEARCH & INFORMATION CORNER**

A novel method for replacement of the dislodged tracheostomy tube: The nasogastric tube “guidewire” technique

Unscheduled replacement of a dislodged trach tube can be challenging for the clinician and frightening for the patient. Dr. Young et al describe a safe and easy technique using a standard nasogastric tube. This can be used under both routine or emergent conditions in both the sedated or combative patient.

The patient is supine with the neck hyperextended. This position aligns the tissue planes and helps with the placement. Adequate lighting, suction, oxygen, and cardiac monitoring should be available prior to the procedure. A selection of trach tubes should be available in sizes both larger and smaller than as well as the current size for the patient, and cuffed and uncuffed. The procedure uses a NGT, lubricated with water soluble lubricant, which is passed through the new trach tube with the inner cannula removed. Approximately 20 cm of the NGT is passed through the tube. This portion is then placed gently into the tracheostomy and advanced into the trachea. The tube should not be advanced more than 7 cm, and at no time should force be used to advance the catheter. The trach tube is now advanced over the “guidewire” into the trachea and the NGT is removed. The cuff is then inflated and the tube secured in the usual manner. (Source: JS Young et al: The Journal of Emergency Medicine, 1996, 14:205-208)

**EMS PERSONNEL NEED BETTER BEDSIDE MANNERS**

Emergency medical personnel need to be more cognizant of the psychological effects that major physical trauma or sudden illness or accident may be having on their patients, says a psychiatric team from the Louisiana State University School of Medicine.

“In some instances... EMS personnel are the only providers of psychologic intervention before the arrival of mental health professionals,” they write in a letter published in the Annals of Emergency Medicine. “Actively listening to patients and encouraging and the tube secured in the usual manner. (Source: JS Young et al: The Journal of Emergency Medicine, 1996, 14:205-208)
worth the effort. “Above all,” they write, “EMS personnel should attempt to ‘remain human.’” (Source: Reuters Health eLine)

**Clogged Tailpipes Pose Carbon Monoxide Risk**

Cars that become buried in snowdrifts can pose a risk of carbon monoxide poisoning, say emergency medicine experts at the Albert Einstein College of Medicine at Jacobi Medical Center in New York.

In a report published in the Annals of Emergency Medicine, they describe several cases in which people attempting to stay warm inside running vehicles in which the tailpipes were clogged with snow suffered carbon monoxide poisoning. Although most of the victims recovered after receiving oxygen in emergency care, one death was recorded.

The group says the public should be warned not to remain in vehicles with the engine running unless the exhaust system has been cleared of snow. In several cases, even cracking a window or door did not prevent the potentially fatal buildup of carbon monoxide inside the vehicle. (Source: Reuters Health eLine)

**AAHP Calls for Guidelines on Emergency Care**

A trade group representing 1,000 HMOs and PPOs has gone on record in support of voluntary guidelines aimed at increasing access to emergency care. As a part of its “Putting Patients First” initiative, the American Association of Health Plans (AAHP) is asking its members to pay for services to treat conditions that "reasonably appear to constitute an emergency, based on the patient’s presenting symptoms." In addition, the AAHP wants member plans to improve on the explanations they give enrollees about their appeals rights and establish expedited appeals processes for situations in which a patient’s life or health is in jeopardy.

The new guidelines received only a lukewarm reception from the American College of Emergency Physicians (ACEP). Although the AAHP has taken a step in the right direction, says the organization, the fact that the member plans are under no obligation to follow the guidelines is cause for concern.

Says ACEP President Larry A. Bedard, MD, “We believe that the only way consumers will be protected and guaranteed emergency care coverage is through federal legislation . . . that adopts the ‘prudent layperson’ definition of an emergency and guarantees a patient’s coverage of appropriate emergency care.” The group notes that Kaiser Permanente has already joined the ACEP in supporting such legislation and encourages the AAHP to follow suit. (Source: Reuters Medical News)

**Early Defibrillation Holds the Key to Success**

A retrospective analysis of 84 atraumatic cardiac arrest victims defibrillated by emergency personnel outside of the hospital found that those who experienced a return of spontaneous circulation after shocks alone fared significantly better than those who required shocks followed by advanced life support. All but one of the 28 patients who required shocks alone survived to discharge home, whereas just 14 of the 56 who required ALS could say the same.

Since call-to-shock time for the survivors was 5.8 minutes and call-to-shock time for the nonsurvivors was 6.4 minutes, researchers conclude that a difference of just one minute increases the chances that shock alone will result in the restoration of spontaneous circulation. The study was conducted by researchers from the Mayo Clinic and the University of Pittsburgh and published in the November issue of the Annals of Emergency Medicine. (Source: Reuters Medical News)

**Call for Authors**

Calling all authors: I am interested in hearing what you have to say and I am sure the rest of the membership is as well. I would like to receive articles about your programs, why you like your job, and interesting and/or innovative things you have seen or are doing. The time commitment on your part is minimal—Bulletin articles are usually no more than one or two typed, double-spaced pages—and they are a great way to publicize your program and, more importantly, the people who make it special. Remember, we also want to hear from those of you involved in ground transports. You are just as important as those who fly. Indeed, this membership section is for all RCPs involved in transport, no matter what role they play.

Let's make this a Bulletin of the membership, by the membership, and for the membership. Anyone interested in contributing to the Bulletin should contact me at the address/numbers listed on the back page. The deadline for the next issue is May 1.

1997 Open Forum is your voice to the ear of the respiratory care profession!

The issues that are near and dear to your heart are valuable to the entire body of AARC professionals.

Your original study, evaluation of a method, device, or protocol, or a case or case study is important. Submitting it is as easy as calling the editorial office at 972-243-2272 or looking for the 1997 Call for Abstracts in each issue of Respiratory Care.

Final Deadline: May 27, 1997
Don’t forget to make your nominations for the Transport Specialty Practitioner of the Year. This honor is given to an outstanding practitioner from this Section each year at the AARC’s Annual Meeting. The recipient of this award will be determined by the Section Chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the Transport Section.

Use the following form to send in your nominations for this important award—

I would like to nominate ________________________________ for Transport Specialty Practitioner of the Year because
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Nominee ________________________________ Your Name ________________________________
Hospital/ School ________________________________ Hospital/ School ________________________________
Address ________________________________ Address ________________________________
City, State, Zip ________________________________ City, State, Zip ________________________________
Phone ________________________________ Phone ________________________________

Mail or FAX your nomination to the Section Chair at the address/number listed on the last page of this issue.
Deadlines for submitting copy for publication in the Bulletin—

- Spring Issue: February 1
- Summer Issue: May 1
- Fall Issue: August 1
- Winter Issue: October 1

Guidelines for the submission of educational conference information for the Bulletin:

- WINTER ISSUE: Submit dates for Feb., Mar., and April.
- SPRING ISSUE: Submit dates for May, June, and July.
- FALL ISSUE: Submit dates for Nov., Dec., and Jan.