Royal College of Nursing

RCN In-Flight Nursing Association

Spring 2006

IN FLIGHT NURSING NEWS

www.rcn.org.uk/inflight

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Letter from the Editor

Change is afoot

There appears to be widespread observation that the industry in which a great number of us have worked for many years, has been changing in a variety of ways. In the last newsletter I highlighted some of these areas and in this issue there is a response from a senior nursing officer from one of the major assistance companies. She wishes to remain anonymous, but I thank her for her comments, written not only in relation to the company's view but also as someone who has worked as an in-flight nurse both in and outside of the office for even longer than I have.

For those nurses who have never worked behind the scenes, her article helps understand the many factors that have to be taken into consideration before patients are brought home. This article can be found on page four.

There has been a noticeable decline in the number of repatriations over the past few months. At first I suffered the usual paranoia common amongst flight nurses, particularly we freelance ones: I wondered, 'was I being singled out?'. Then, on speaking to other in-flight nurses, I discovered that we were all feeling the pinch.

Since this has been going on for some time, I suspect that perhaps we are witnessing a general decrease, for several reasons, which I discuss further on page two. With this in mind, perhaps those of us who do not have an income, apart from flight work, should be considering other options. This is not very easy if you have been outside of the hospital setting for any length of time. As such, IFNA Chair, Gerry Bolger, has offered to help point us in the right direction by showing the various routes we should follow to find our way back in to the NHS, and this information will soon be available on our website at www.rcn.org.uk/inflight

Thank you to Caroline Hinder for taking the time to describe Lufthansa's PTC service, the facility aboard a Lufthansa aircraft that provides a private, sealed-off area in which an acute patient can be transported on a scheduled flight.

Finally, I would like to thank all of you who attended our two-day conference at the RCN last November. Delegates came from near and far and I hope you all felt it was worth it. Thank you also to all of you who took the time and trouble to fill out the feedback forms. These are essential to make sure that we are providing the right balance for everybody (well, as near as we can). All your comments have been noted and we will endeavour to improve, where you felt improvements were necessary, for next November.

Personally, I always feel that one of the great benefits of these conferences and the study days is that they provide a chance to share ideas and experiences. This conference was organised by the RCN events team, who did a sterling job at bringing together a rather unusual collection of people and making it all such a success. Thank you to them.

Val Pitman

Letter from the Chair

Gerry Bolger recounts the latest in-flight news and concerns

A slow start – guidance on finding alternate sources of work

Christmas has come and gone, spring is in the air, and work seems to be slower to trickle in than normal, with a sharp downturn in nurse-led repatriation during the recent months. There appears to be a number of reasons for this (*see Val Pitman's article, this page*), and the IFNA Committee have been receiving several calls and emails on the topic. We are aware of the impact that not working means to in-flight nurses, and in response we have prepared a guidance sheet on how to find alternative nursing work (both within the NHS and in the independent sector), which includes information on clinical skills and PREP. This document is available from the IFNA website at: www.rcn-ifna.org.uk

PDF update

At our recent two-day conference, RCN Advisor in Nursing Practice Bernie Cottam distributed to members the consultation document on the Professional Development Framework. This consultation was widely promoted within the RCN, and closed in early January 2006.

The PDF Management Group has since held a briefing with RCN forum chairs. The purpose of this meeting was to brief all the forum chairs and share the information from the consultation with them, as well as to get a sense of next steps and to feed our comments back to RCN Council. Council will have met by late February 2006, and all this will set the direction of what will happen next.

The outcome will mean radical changes to all forums, IFNA included. While we cannot speculate what this means, be assured that the IFNA has been vocal in ensuring that the importance of specialist practice remains at the heart of the RCN. We will brief you once RCN Council meets to discuss the PDF in late February.

Conference feedback

The RCN Events Unit has now analysed the feedback from members attending the November 2005 two-day conference. Feedback has been extremely positive, and IFNA members have given very helpful comments to the committee to help us shape future events.

Competencies

I have recently managed to bring the two-year work on in-flight competencies to the Accreditation Unit within the RCN.

The Unit was impressed with the standard and width of the competencies, and approved a one-year accreditation, subject to some minor adjustments. The reason for one year is to allow the RCN to align all the competencies to the Knowledge & Skills Framework (KSF).

These competencies are available on the RCN website and will also be sent out to members. The IFNA Committee and I wish to thank the many members who have inspired this work, and helped shape it to the current standard. The competencies will be assessed and updated on a regular basis to ensure they incorporate the clinical practice and legal implications of working in in-flight nursing.

The implications of avian flu

As we go to press, the risk of avian flu, more commonly known as bird flu, has come closer to our shores (*see article on page three*). While the Government and the Department of Health have a robust contingency plan, the implications of what will happen, especially in relation to travel, are still not clearly understood. Public response will invariably mean that travel may be reduced, especially in affected countries, and this in turn could reduce further work. The issues for in-flight nurses will mean they may have to consider alternative sources of income.

The beginning of the end for in-flight nurses?

Val Pitman looks in in-flight nursin

There have definitely been fewer escorted repatriations recorded over the past few months. I am unable to give exact figures, but it has been commented on by most of the people I have spoken to. This is a bit of a mystery, as the number of people travelling overseas is increasing every year. I have a couple of theories but, if anyone has other ideas, please share them with us by writing to me via the newsletter.

Fewer freelancers required

First of all, I believe that there are more nurses working 'in house' for the various assistance companies. This means that these nurses are asked to do the repatriations before anyone else, and quite rightly so. Of course, it is only in the event that none of them are available that a freelancer is called upon. However, this time of year is historically one of our busiest, yet even 'in-house' nurses are finding that there is not enough flying work.

into a few reasons for the decline g work

Another factor is that some of the main assistance companies have offices overseas, namely in Australia, the United States and in the Far East. The upshot of this is that they use their own nurses to escort patients coming back to the UK.

So, what else is going on?

Apparently, the skiing conditions are better in Europe than they've been for many years. This means that there are fewer ski injuries, as the landings are a bit softer! Good news then for the skiers...

This time of year also means trips to the Canary Islands, and again there are fewer instances where in-flight nurses are required. Why? No snow conditions to be considered there, as I don't think folks go to Tenerife to ski down Mount Teide! For this, my feeling is that, over the years, the standard of treatment in Spanish clinics has improved so much that insurers are finding it cheaper to keep the patients out there until they are fit to fly alone than to bring them home by nurse-escorted stretcher. It's a long time since I've brought back someone with an un -operated hip, which was something I used to do fairly frequently.

The fact that BA has stopped carrying stretchers has had some impact as well. Apparently there are more air taxis, although I haven't noticed a dramatic increase. Thank goodness that GB Airways continues their stretcher services.

And in future

To end on a more positive note, I believe that more and more people will be travelling to the new and future member states of the EU where the health care facilities are comparatively poor. Therefore patients will require repatriation sooner rather than later. I don't feel quite ready to hang up my scoop just yet, as I hope that things will pick up but I am definitely considering evening classes in Romanian!

Avian flu edges closer

There have been a series of outbreaks of a virulent form of avian influenza, known as the highly-pathogenic H5N1 (or A/H5N1) strain, starting in South-East Asia at the end of 2003. Fresh outbreaks of the H5N1 virus (avian flu, or bird flu) are being reported every day across Europe, the Middle East and Asia, creating more opportunity for human infection and increasing the risk of the virus developing into a pandemic. Public health officials and organisations around the world remain on high alert.

The following countries have recently suffered from confirmed or suspected outbreaks in poultry or wild birds:

- Nigeria
- Turkey
- Romania
- Slovenia
- Croatia
- Ukraine
- Austria
- Italy
- India
- Hungary
- Egypt
- Iran
- Germany
- France

(An isolated case in imported birds in quarantine in the UK in October 2005 does not affect the UK's avian influenza-free status.)

Avian influenza is largely a disease of birds. Despite large outbreaks in poultry, only about 140 people have so far caught the disease. Of these, about half have died. All human cases have occurred in Vietnam, Thailand, Cambodia, Indonesia, China and Turkey, as well as a recent case in Iraq. Almost all are thought to have caught the disease from infected poultry. There has been no sustained human-to-human transmission: the virus does not pass easily between people. Medical experts warn that the avian influenza virus could combine with influenza viruses already circulating in the human population or adapt into a form that could be transmitted readily between people. It is impossible to predict when this might happen. But if it did, it could trigger a global human flu pandemic.

As the risks from avian influenza are considered small, the UK's Health Protection Agency does not at present advise tourists visiting affected areas to carry anti-viral drugs. There have been no cases of avian flu in travellers as yet, but the situation is changing rapidly, and it is essential you take heed of the news and the information supplied on line at www.fco.gov.uk and www.hpa.org.uk

A more commercial view of repatr – an opinion piece

Having been a repatriation and office nurse for quite a long time I have seen plenty of changes – not all for the worst – although I do look back fondly on those trips where something had gone wrong and we ended up on a beach in Bermuda for a few days, waiting for things to be sorted out! In light of these changes, I thought it would be a good idea to put forward the more commercial view on repatriation, as I have not seen this represented before, but in the process I am sure that I will raise more than a few hackles.

Adapting to change

There are some very good, very experienced repatriation medical crew around, who are the backbone of this work. But I notice that some have found it easier than others to adapt to industry changes. How I wish *all* repatriation crew would spend some time in the office, to understand the other side of the coin.

Change is inevitable as the travel insurance market hardens. FSA requirements have added costs, work has concentrated into the hands of fewer, and contracts are now very hard fought for and very hard won. These days, assistance companies will even pay for good contracts.

Like car manufacturers for whom last year's add-on air bags are next year's standard – and at no extra cost – assistance companies have to continually work at cost-saving in a very competitive market.

Medical expenses overseas are the biggest culprit, and try as we all do, there is never enough that we can do to control these escalating costs and sharp practices – this year, Turkey and Bulgaria win all the medals for this.

Cost-saving and repatriation

So – cost saving turns its attentions to repatriation. Is this fair or not? Well, yes, and no.

No, when:

- patient safety is compromised
- crew are expected to tolerate staying in a substandard hotel or expected to work too many hours with too little sleep.

Yes, when:

- patient comfort might not be quite as good, but safety is not compromised
- a nurse has enough time to rest and see the patient, but is flying out and back by charter
- an itinerary involves very early or late hours, when nothing else is available, but it means getting the patient home soonest.

Charter flights

Charter flights provoke so many complaints from crew. I can't help feeling that much of this is because air miles, tier points and/or Luton airport are involved. Yes there can be long delays, the club lounge is not available and space can be at a premium. But is the patient not alternatively sat in a clinic rather than an airport waiting to come home? Are we really not able to make a patient pretty comfortable if they have to wait? Why not ask to use the club lounge in the case of long delays, and pay for this if necessary or possible? And is the leg room really that much different on Easyjet compared to BA Economy? I think not – it's two inches, I have measured it.

Itineraries

Yes, I agree they have tightened, as they must to keep up with market demands. Almost gone are those lovely days when we routinely had two nights out in Turkey, or out to France one morning and back the next afternoon. It was just not necessary – very nice but not necessary.

Undoubtedly, money can be wasted when we get it wrong in the office. IFNA editor Val Pitman's example of a stretcher being used when a seat would do happens too often. But getting the correct picture of the patient, while you are in an office, possibly quite far away, is not always as easy as it seems.

So what should we as nurses do?

I agree that we should always point out to assistance companies where we are not happy about a job – *before* we go out – and should refuse a trip on safety grounds. (But I get weary of crew who don't like one-day trips, charters or uninteresting locations.) I am fully supportive of the IFNA setting out minimum requirements for assistance company practices – this work definitely needs more regulation.

But I feel strongly that too many repatriation nurses do not think about the other side of the coin, and also do not quite appreciate the super job we have.

iation work

Where else can we:

- get paid round the clock, from door to door, 'working' or not?
- get paid for as many hours on end in a hospital?
- have patients who are (nearly) always delighted to see us?
- work quite so independently?
- have a job that offers a glimpse of so many parts of the world?
- have the joy of 1:1 nursing after the rigours of the NHS?
- sometimes manage that good meal in a French bistro – all paid for?
- get the sort of trip referred to by Catherine Gates in the Autumn 2005 *IFNA Nursing News* – to Greenland?

And – why are so many of us still hanging in there?

I feel as strongly as I ever did about patient safety, and even though I work in a very commercial environment, I will never knowingly compromise that. But I have just become more adept at working out where the real priorities are.

I think we should all think about the whole picture before we bite the hand that feeds us, and before underwriters start looking at cheaper ways still of repatriating patients, for example, by using overseas doctors or nurses. It happens already, and I have no doubt that it could easily extend unless we are prepared to accept the tough commercial realities of repatriation work today.

By Anonymous – with apologies, as there are a few commercial sensitivities.

TRAVEL ALERT

Rabies in India still a hazard

Travellers visiting India need to be more aware of the persistence of rabies as a serious public health problem in India.

A British woman died of rabies contracted during a trip to Goa in May last year. The 39-year-old woman from Bury, Greater Manchester, had been bitten by a dog in Goa and became unwell after her return to the UK. She was diagnosed with rabies and had treatment at the Walton Centre for Neurology in Liverpool.

Since Goa is a fairly common holiday destination, here are a few pointers should you be there and have the misfortune to be get bitten:

- wash the wound immediately, using soap or detergent; apply alcohol if possible.
- get medical attention, fast. Go to the nearest doctor or hospital. If you need a rabies vaccination, they will need to give it to you straight away. Ask for 'human diploid cell vaccine', if possible. If you have any problems, contact the nearest British Consular official.
- make a note of when and where the incident happened, what the animal looked like, and whether it was wild or a stray.
- if the animal belongs to someone, try to find the owner as soon as you can. Ask them to keep an eye on the animal for two weeks, and to tell you if it becomes ill or dies. Ask them if the animal has had the rabies vaccine. If it has, ask to see the certificate. Remember, even if the animal has been vaccinated, you could still be at risk.
- tell the local police.
- see your doctor as soon as you get back to the UK.

There are clear guidelines from the World Health Organization that European and North American travellers to the Indian subcontinent take pre-exposure vaccinations against rabies and this is something to be considered, even on a short trip.

Further information on rabies can be found at the Centre for Disease Control and Prevention website: www.cdc.gov

STOP PRESS: the latest in-flight news

Revised USA security measures

As of 22 December 2005, the United States' Transportation Security Administration has changed it procedures as to what is and what isn't allowed on flights.

Items that are now allowed

- metal scissors with pointed blades, up to four inches long
- metal scissors with blunt blades, and plastic scissors
- blunt tools, such as screwdrivers, wrenches and pliers, up to seven inches long
- nail clippers
- nail files
- book matches
- tweezers
- corkscrews.

Items that remain prohibited

- knives
- box cutters
- tools with sharp edges, such as saws
- tools that could be used to bludgeon, such as hammers
- all tools longer than seven inches
- lighters and lighter fluid
- ice picks
- baseball bats, hockey sticks and ski poles
- guns and starter pistols
- axes and hatchets
- pepper spray
- night sticks and martial arts weapons
- fireworks
- camp fuel and gasoline
- turpentine and paint thinner
- spray paint

Note: The USA Transportation Security Administration has indicated, however, that it will now instigate increased random additional searches after passing through carry-on bag checkpoints, including 'pat-down' searches of arms and legs, along with torso.

Caroline Hinder has a look at the airline's impressive patient transport compartment

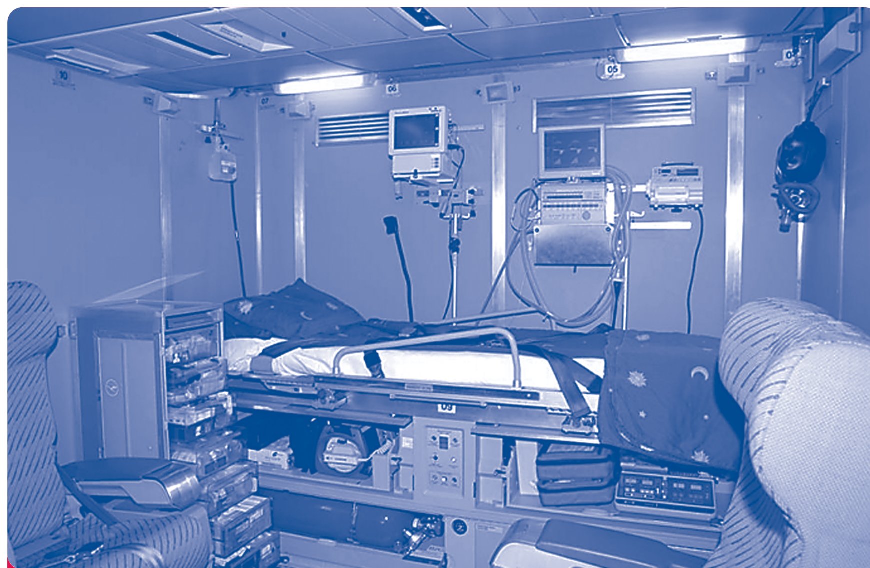
Lufthansa's PTC service ...

In November I was lucky enough to accompany the CMO of Axa Assistance, Dr Mike Braida, as an observer on a repatriation from Miami to Frankfurt using the Lufthansa PTC (patient transport compartment) service.

Lufthansa has offered the PTC service since 1996, and it operates on inter-continental flights between Frankfurt and, up until now, 62 destinations, including the USA, the Middle East and the Far East. It is a completely separate room, measuring six square metres and assembled into the forward economy section of seats – 16 seats are removed and the PTC is fitted on the outbound flight and sealed. This is an excellent position, and very different to the scheduled stretcher returns we are all used to where you are usually situated at the very back of the aircraft with the worst turbulence. We did experience severe weather during the flight and although obviously bumpy, it was far less unpleasant for the patient than for those at the very back of the aircraft.

The PTC is comprised of one stretcher with storage underneath for everything from a bandage to an infusion set, which is an adapted meal/duty-free trolley for drugs and infusions bags. The medical equipment includes a propaq monitor, a breas ventilator, three syringe drivers, a defibrillator, a blood gas analyser, and 13,000 litres of oxygen. But by far the most important thing the PTC offers is privacy and dignity preservation for the patient. There are two old-style business-class seats for the doctor and nurse to sit in. Lufthansa provides their own nurse with an assistance company doctor, and observers are always welcome.

Lufthansa arrange all crew tickets at a very good price as part of the PTC package, and you are accommodated in a good hotel, usually with the Lufthansa flight crew. The experience was invaluable, and very different from the days of carrying 17 pieces of kit on a three-sector flight with difficult customs personnel who are convinced the laryngoscope is a gun!



PTC arrives at the destination "ready to use"

The patient was stable during the transfer and upon arrival at Frankfurt we were met by the Lufthansa ground staff, who transferred us to the air ambulance that was waiting next to the 747.

Lufthansa are working with assistance companies in providing the PTC at a very competitive price. Despite the need of an air ambulance for the relatively short final transfer to the UK, because of the clearly shorter flying times and therefore lower costs in comparison to ambulance jets, it seems that this is an excellent alternative when considering the transfer of an intensive-care patient from long-haul destinations.

What a shame our own national airline couldn't have come up with the same idea – instead they just banned stretchers altogether.

Passenger cabin with Patient Transport Compartment

New BLS guidelines

The latest European Resuscitation Council Guidelines for Resuscitation (CPR) were released on 28 November 28 2005. This overview is intended to provide you with information on the enhancements to the guidelines on CPR.

Research

The recommendations made by the ERC are based on an international consensus developed by the International Liaison Committee on Resuscitation (ILCOR). The international review took 36 months and included input from 380 international experts. The guidelines are aimed at all health care workers.

Enhancements

The new CPR guidelines focus on a 'back-to-basics' approach and have been made easier for laypeople and health care professionals to learn. The following points summarise the main changes:

- the decision to start CPR is made if a victim is unresponsive and not breathing normally
- rescuers should be taught to place their hands on the centre of the chest, rather than to spend more time using the 'rib-margin' method
- each rescue breath is given over one second rather than two seconds
- the ratio of compressions to ventilations is 30:2 for all adult victims of cardiac arrest. The same ratio should also be used for children when attended by a lay rescuer
- for an adult victim, the two initial rescue breaths are omitted, with 30 compressions being given immediately after cardiac arrest is established
- a single defibrillator shock (at least 150J biphasic or 360J monophasic) is delivered, immediately followed by two minutes of uninterrupted CPR, without a check for termination of VF or a check for signs of life or a pulse.

Adult Basic Life Support Algorithm

Reasoning

The 2005 guidelines emphasise that high-quality CPR, particularly the use of effective chest compressions, contributes significantly to the successful resuscitation of cardiac arrest patients. The guidelines simplify CPR information so that more rescuers would learn, remember, and perform improved CPR. Studies showed that effective chest compressions increase blood flow through the heart to the brain and other vital organs, buying a few minutes until defibrillation can be attempted or the heart can pump blood on its own. The guidelines recommend that rescuers minimise interruptions to chest compressions and suggest that rescuers 'push hard and push fast' when giving chest compressions.

... and for the animal lovers amongst you ...

In-flight animal care

Horses being transported by air around the world have always had their own 'flight attendants'. Now, according to *Dogs Today* magazine, this care is being extended to cats and dogs. IRT, the world's largest horse transporter, now offers regular shipments of dogs and cats from the UK to Australia and New Zealand every six weeks. Find out more at www.irt.com

Another possibility for us in the future perhaps?

SAFETY IN THE NEWS ...

Are low-cost airlines compromising airline safety?

RITA MODY aks whether it is worth using charter flights in light of new safety information

Anyone who saw the *Dispatches* TV programme about Ryanair on13 February 2006 will have been shocked by how easily safety and hygiene standards were compromised within this airline.

We have all been sent on repatriations using low-cost airlines on the basis that this is the best option for a particular repatriation. There is no doubt that in certain situations (better schedule, only direct flight, etc.) there is a good argument for using these airlines. More frequently, low-cost airlines are being used to fly a nurse out (and occasionally even repatriate someone back to the UK).

However, the programme should also highlight to the insurers and assistance companies how the differences within the way certain airlines operate may have an impact on the escort and even the repatriation. Cost containment is always a major issue and these airlines seem to be a godsend for the travel industry, but this option should not be seen purely as a money saver. These airlines are low cost for a reason and it seems this programme highlighted why, with this particular company, it is.

For more information on airline safety, visit www.airsafe.com

Airbus A380 – double the passengers, double the risk

The A380 is able to carry twice the number of passengers as many of today's planes – which almost doubles the chances of someone needing urgent medical attention on any given flight.

Medical emergencies are thought to be the most common reason for diverting aircraft, and given that more elderly people fly these days, the frequency of these situations and consequently the number of diversions are likely to increase. As you may be aware, a UK government report from 2000 showed that the number of medical emergencies can be as high as 1 in 1400 passengers flown. A subsequent US study of one airline showed that eight per cent of on-board medical incidents resulted in the aircraft being diverted to the nearest airport.

Airports around the world will be accepting the A380, despite the extra pressure it puts on actual runways and on runway traffic. Its wingspan alone is 15 metres wider than the Boeing 747-400's, and some taxiways are being moved to give adequate clearance for it. It is also heavier than the Boeing, so runways must be strengthened to take the increased weight.

There is some discussion as to whether or not there is any justification for a doctor or nurse to be carried aboard all A380s. No decision has yet been reached, but if this is the case, I'm sure we would welcome it.

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Dates for your diary

IFNA study days at RCN HQ in London:

- **25 March 2006**
- **15 July 2006**
- **17–18 November 2006 (conference)**

Topics to be covered are yet to be decided, but will soon be available on the website: www.rcn.org.uk/inflight

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The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies