

IN FLIGHT NURSING NEWS

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Contents

- 2 Letter from the Editor – II
- 2–3 News in brief
 - Meet the committee
- 4–7 A rough guide to spinal cord injuries
- 7 In-flight nursing course
- 8 IFNA survey

Further information

Send contributions for the next issue by 6 July 2007 to the Editor:

Rita Mody
Email: ritamody@hotmail.com

Letter from the Chair

Change is in the air!

GERRY BOLGER updates members on a turbulent (in a good way) year ahead.

So far

The IFNA is busy as ever, and I am happy to report that committee members have completed the processes of having the work on the competencies accredited by the RCN Institute. These are the first set of competencies for in-flight nurses, and will be refreshed on an annual basis each autumn to reflect any changes, both professional and legal, which are relevant to us.

As you may know, the committee has dramatically changed. While we say farewell to our outgoing committee members Catherine Gates, Terry Little, Val Pitman and Chrissie Timms, we are also delighted that so many members expressed an interest in being co-opted. The committee certainly had a difficult task selecting from its members, many of whom had vast expertise.

Coming soon

Committee members are also completing work on standards, which have been developed in the last year, for in-flight nurses. This will be available on the IFNA website: www.rcn-ifna.org.uk (note this is a site external to the RCN – see news article on page three).

In recognition of the difficulties faced by members seeking access to educational funding, the IFNA committee has agreed to set aside a proportion of its funding towards providing a small bursary. Applications need to be done electronically, and forms and conditions are available from the IFNA website.

Finally, the IFNA has accepted an invitation to join a task group on pandemic flu. We hope to provide both input on the wider nursing issues and those issues that affect in-flight nurses. As we go to press, the February outbreak in Norfolk shows that the UK is as much at risk as any other country.

Letter from the Editor: Part I

Hope you had a pleasant journey

Outgoing editor VAL PITMAN reflects on her inspiring years on the committee.

I have now handed the newsletter over to Rita Mody since my four-year term as a committee member has ended. There have been other leavers and joiners on the committee, as described by IFNA Chair Gerry Bolger on this page (and see profiles, pages two and three).

I would like to say how pleased I am to have served on the committee, as I truly believe in the work that the IFNA does, although, at times, it has been an uphill struggle. We all try to do 'our bit', but I have been constantly amazed by Gerry, who, despite having a very busy job in the

NHS, devotes so much time and energy to the IFNA. Likewise, Caroline Carter, who toils away, so often behind the scenes, but who produces excellent study days time after time.

I would like to thank so many people who have contributed to the newsletters, namely Mark Jarratt in this issue (see his article, starting on page four). There are too many of you to name personally, but to those who, over the past four years, I have pestered, flattered, cajoled and generally beaten down until you have given in and sent me articles ... thank you one and all!

I wish Rita lots of luck as editor (please see her letter on page two) – it can be a fairly onerous task! My help and support will always be there – however, I doubt she will need it.

**Letter from the
Editor: Part II**

Preparing for take off

Incoming editor RITA MODY fastens her seatbelt and looks forward to her new role.

Thanks to Val Pitman for her huge contribution to the IFNA as newsletter editor and committee member. It is a fairly daunting task as the newsletter editor to ensure we are providing our members with the information they want and need.

We also have a few new faces on the committee, all of whom offer invaluable experience, as you can see in our profiles opposite. And with these changes, we thought it would be a good time to have your views on how we are doing. You can find the IFNA survey on page eight. Please take the time to fill this in.

As well as the recent avian flu outbreak, which will, in all likelihood, affect the travel industry, there have once again been disruptions to airline travel from the UK carrier British Airways. No doubt there were some flight nurses who were affected by this, either in cancelled repats (and therefore income), being kept abroad for longer, or in having to fly on routes that increased travel time for them and their patient. Luckily, the dispute ended with relatively little disruption – however, all flight nurses are very much aware of how our work relies on the smooth running of airlines. Having said this, for those who would like some light comic relief from these wider issues, the website www.skygod.com offers a few humorous insights into those who work in the aviation industry.

I am looking forward to being the IFNA newsletter editor. Val did a great job and I hope to follow in her experienced footsteps.

NEWS IN BRIEF

Is this the way all hospitals will be heading?

Fit to fly (FTF) certificates may not be given out by some French hospitals anymore. Two hospitals have recently refused to give these out, thus leaving the assistance companies' doctors to complete an FTF certificate prior to sending nurses out for a repatriation.

Avian flu in UK

No human casualties have yet been known to have occurred from the

outbreak of avian flu amongst birds in Suffolk in February. However, the latest human case of avian flu (as we went to press) has been documented in Lagos, Nigeria, where a 22 year old is suspected to have died from it – her mother died from similar symptoms in early January 2007. Tests are ongoing to confirm cause of death. For the latest information, visit www.cdc.gov

Fancy a sneak peek?

For the new series of *City Hospital* to be aired in summer 2007, the BBC spent

Meet your committee



Committee, from l-r: Alan Sheward, Gerry Bolger, Caroline Carter, Siva Murugiah, Rita Mody, Mark Payne, Rachel Leader, Ryan McNay

GERRY BOLGER – Chair

Gerry is working in the NHS as the National Project Director for 'Hospital at night', the transforming programme that supports safer clinical practice at night and out of hours, whilst supporting the reduction in junior doctors' hours under the working time directive (WTD).

He has previously worked as an Assistant Director in Workforce in North Central London Strategic Health Authority (SHA), and previously as Deputy Director of Nursing in a large district general hospital in London. His background is medicine and emergency care. He holds a trauma nursing qualification, as well as the RCN

in-flight nursing certificate, and has recently completed a masters in health management at London City University.

As well as working in the NHS, Gerry actively flies as a freelance in-flight nurse for several in-flight assistance companies and lectures on in-flight care and professional issues in nursing. He was re-elected unopposed in 2004, and also elected by the committee as Chair. Email: ifna@rcn-ifna.org.uk

MARK PAYNE – Vice Chair

Mark is based in the Isle of Man, and is the In-flight Coordinator for the Isle of Man Health Services, managing and

some time interviewing a repatriation doctor and the company MedAire, which provides the onboard emergency medical assistance for airlines (MedLink). For a sneak preview, go to www.medaire.com and look under 'newsroom'.

Website update

For those of you who have tried to log onto the IFNA website via the RCN website, you will have noticed it appears to be severely out of date! The IFNA does update its website regularly (thanks to Chair Gerry Bolger), but the

address that can be accessed via the RCN website is out of date. This link will be deleted, but in the meantime, the up-to-date version is available externally at: www.rcn-ifna.org.uk. As well as all the latest information, there is now a discussion forum where members can obtain information and views from other forum members.

Don't forget ...

... to renew your membership with the IFNA when you renew your RCN membership. Those who don't are now

automatically removed from our register with the RCN and may no longer receive newsletters, study day information and the like. Make sure you continue to have the IFNA as one of your current forums by going on the RCN website and checking which forums you belong to: www.rcn.org.uk

IFNA study day

17 March 2007. This day – which will provide manual handling and basic life support (BLS) certificates – will be popular, so please book early.

arranging all primary and secondary transfers to the UK mainland for specialist and tertiary services. Mark was re-elected unopposed in July 2006.

Email: Mark.Payne@gov.im

CAROLINE CARTER – Secretary and Study Day Organiser

Caroline has held this position since January 1999. In that time, she has also arranged the first two of our three weekend conferences. Caroline's background is as an intensive therapy unit (ITU) nurse of 16 years, holding the Dip HE in critical care, and as a flight nurse of 15 years, holding the RCN IFN award course. Caroline has completed over 400 transfers in both fixed and rotary wing aircraft. She was re-elected unopposed in 2004.

Email: carolinecarter1@tiscali.co.uk

RITA MODY – Newsletter Editor

Rita has an emergency nursing background, completing the A&E nursing qualification, as well as previously working on board cruise liners worldwide and in head and neck surgery. She is an in-flight nurse who holds the RCN in-flight nursing certificate. Rita worked for several years in an assistance company and currently works within operations of a repatriation company and undertakes repatriations.

Rita currently teaches on the RCN in-flight nursing course and also trains pilots

and cabin crew on aviation physiology and in-flight medical emergencies. She was elected unopposed in 2004.

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SIVA MURUGIAH – RCN In-flight Course Director

Siva runs the in-flight nursing course, which is now accredited at level 3 (*see article, page seven*).

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ALAN SHEWARD

Upon qualifying, Alan started work in medical admissions and followed this with intensive care, becoming a shift leader over a four-year period. Whilst in this post, Alan also worked part time in A&E. After completing the ENB 100, ENB 998 ALS Instructor and other in-house leadership courses, Alan succeeded in obtaining a position as a senior charge nurse in A&E full time, following this with an acting position as senior nurse. Alan then returned to a paediatric and adult intensive care unit as an extracorporeal membrane oxygenation (ECMO) coordinator. Alan's time as an adult ECMO transport coordinator has given him such skills that ensure his expertise is utilised in the transfer process of patients. Alan currently works as a business manager/senior nurse in A&E. He was elected in 2006. Email: alan.sheward@virgin.net

RYAN MCNAY

Ryan qualified as an RGN in 1991, having trained in Dumfries, South West

Scotland. His initial experience is mainly in orthopaedics and trauma. He has been based in Jersey since 1997 and moved into the intensive care field in 2000 to broaden his knowledge during complex transfers of patients requiring treatment in the UK. After completing the clinical considerations in aeromedical transport (CCAT) course in 2002, he was invited to teach on the in-flight training course, run in Jersey. He has previously been an RCN safety representative (between 2001 and 2004).

Elected in 2006, he hopes to learn as much as he can from this position and in turn offer his services where best he can. Email: ryanmcnay@localdial.com

RACHEL LEADER

Rachel lives in Belfast and has a background in emergency nursing, intensive care, neurology and orthopaedics. She currently works with the NHS and the private sector. She has previously worked as a transfer nurse on ground transfers, and holds the RCN in-flight nursing and CCAT course certificates, as well as a diploma in trauma.

She is working at having in-flight nurses trained within the Belfast area for transfers out of Northern Ireland. She was elected in 2006. Email: leadercivr@hotmail.com

Please note that RCN Adviser Bernie Cottam is also available at email: bernie.cottam@rcn.org.uk

A rough guide to spinal cord injuries

MARK JARRATT leads members through the basics of acute spinal cord injuries (SCIs), with a focus on the complications of this catastrophic injury. It is aimed at those with limited experience of looking after these patients and who are contemplating being involved in or organising a transfer.

Background

SCIs have been known about and recorded since antiquity: 'In about 2500 BC, in the Edwin Smith papyrus an unknown Egyptian physician accurately described the clinical features of traumatic tetraplegia and revealed an awareness of the awful prognosis with the chilling advice: an ailment not to be treated.' (Grundy D, Swain A, *ABC of Spinal Cord Injury*, 3rd ed, 1996) This view persisted even into the 20th century, with little improvement in treatment. However, the ancient Egyptians did at least manage to catheterise their patients: they used reeds!

At the start of World War II, the life expectancy of a patient with a spinal cord injury was less than 12 months: 'Mortality associated with tetraplegia was still 35 per cent in the 1960s' (Grundy D, Swain A, 1996). The incidence of pressure sores and urinary tract infections was high and, ultimately, most lives were lost through sepsis. In 1944, in the run up to D-day, London-based neurologist Ludwig Gutmann (later a Sir) was asked by the British War Department to set up a unit to cater for the expected spinal cord injuries from D-Day and the battle for France. Gutmann chose Stoke Mandeville Hospital, and the modern era of the successful treatment of spinal cord injuries was born.

Types

Most SCIs result from trauma, although some 10 per cent are from non-traumatic causes: abscess, tumours, infarcts, aortic aneurysm repairs and the like. 'At present, the annual incidence of spinal cord injury within the United Kingdom is about 10 to 15 per million of the population' (Grundy D, Swain A, 1996).

There are two types of SCIs: upper motor neurone lesions and lower motor neurone lesions, which are sometimes called cauda equina lesions.

Upper motor neurone lesions are those SCIs that occur above the 12th thoracic level, (T12 – see figures 1 and 2 for information on these points) and are spastic lesions. These

lesions initially present with a flaccid paralysis – this is due to spinal shock – and spasticity develops after the first week. Although mild at first, the spasticity increases steadily, peaking at about six months post injury.

Lower motor neurone lesions occur in patients with an injury at L1 or below, in the cauda equina, where there is no reflex activity. These patients will always have a flaccid paralysis.

Common sites

There are three common sites where most SCIs occur: cervical levels of C5/6, thoracic levels of T5/6 and levels of T12/L1. '... 44 per cent are cervical injuries, 41 per cent are thoracic injuries and 15 per cent are lumbar/sacral injuries...' (Grundy D, Swain A, 1996).

Associated injuries

Nearly all cervical injuries have to hit their head in order to cause the cervical vertebrae to fracture and/or subluxate. Therefore, nearly all cervical cord injuries have a degree of associated head injury!

Thoracic injuries commonly have associated injuries; it is fairly safe to assume that all thoracic vertebral fractures have rib fractures, often with associated pneumothorax, haemothorax, or both. Pleural effusions are also very common with these injuries. 'There is a high incidence of cardiac contusion in thoracic injuries with a potential for arrhythmias.' (British Orthopaedic Association, *The initial care and transfer of patients with spinal cord injuries*, 2006)

Respiratory issues

Cervical and thoracic injuries have enormous potential to develop respiratory problems in the first couple of weeks post injury.

Patients with cervical cord injuries have a degree of respiratory compromise, as most of the muscles involved with breathing simply do not work anymore. The diaphragm and accessory muscles can remain functional, depending on the level of injury, however, these are not designed to do all the

to fluid overload and subsequent strain on an already compromised respiratory system.

‘Spinal shock (neurogenic shock) is the body’s response to the sudden loss of sympathetic control. It occurs in cervical and high thoracic lesions (above T6). Due to lack of vasomotor control, significant hypotension results. Bradycardia occurs as a result of unopposed effects of the vagus nerve. A systolic blood pressure of 90 may be normal in these patients.’ (British Orthopaedic Association, 2006)

Gastrointestinal

In the first 24 to 48 hours, all SCIs have a degree of paralytic ileus that can last several days. Therefore, patients need to be kept nil by mouth; IV fluids and a naso-gastric tube are essential until normal bowel sounds have returned. Due to the ileus, they tend to be quite gaseous and occasionally need a flatus tube to relieve the distension. Altitude poses additional problems, as gases expand, increasing the risk of vomiting and diaphragm splinting. An established bowel care regime – generally, glycerine suppositories followed by a daily manual evacuation – must be implemented as soon as normal bowel sounds return.

Autonomic dysreflexia

This is a medical emergency; it is a complication of an SCI, and affects those with lesions at T6 and above. Autonomic dysreflexia can be triggered by any strong, often painful stimulus that arises from below the level of the spinal cord lesion. This stimulus travels along the nerve fibres to the spinal cord until it meets the damaged section, where it can go no further. At this point, it travels out from the spinal cord along the autonomic nerves and stimulates their supply, causing the release of neurotransmitters. Common symptoms include: a pounding headache, hypertension, pain and red rash above the level of the lesion. The most important of these is the blood pressure; patients can go from their usual hypotensive state to one of extreme hypertension within a relatively short period of time.

work of breathing alone. A percentage of all cervical injuries will need respiratory support, both invasive and non-invasive, within the first two weeks of injury. The majority will be intubated and ventilated and may require ventilatory support for two months or more.

These patients can deteriorate very quickly and will suffer respiratory arrest within minutes of showing signs of respiratory distress. An increase in respiratory rate with slowly rising partial pressure of carbon dioxide (PCO₂) levels, or even normal arterial blood gases (ABGs), should be seen as a sign of impending respiratory failure. Other contributing factors that add extra strain on the respiratory system include: heavy smoker, chest infection and fluid overload. Early elective tracheostomy is considered in most patients, as weaning from ventilatory support is often a long, protracted process.

Thoracic injury patients are different in the fact that their respiratory problems are caused by the associated chest injuries. Pre-transfer assessment is vital in order to determine the type and extent of chest injury.

Cardiovascular issues

Due to unopposed parasympathetic activity, SCI patients are normally hypotensive and remain so all their lives – tetraplegics will often have a ‘normal’ B/P of 80/40 or even lower. A common mistake in the first few hours post injury is to try and reverse hypotension with fluid resuscitation, leading

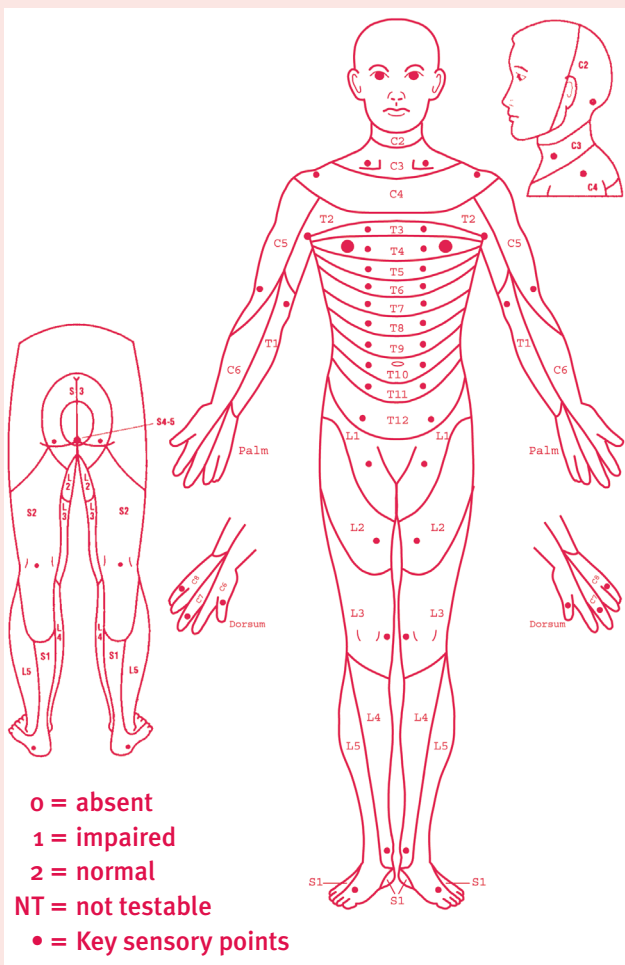
Figure 1

MOTOR

Shrug shoulders = C4	Spread fingers = T1
Bend elbows = C5	Flex leg/hip = L1/L2
Pull back wrist = C6	Straighten knee = L3
Straighten arm = C7	Pull foot up = L4
Open or close fingers = C8	Push foot down = L5/S1

Figure 2**SENSORY**

Key sensory points



C2 to C4. The C2 dermatome covers the occiput and the top part of the neck. C3 covers the lower part of the neck to the clavicle (the horizontal bone that goes to the shoulder). C4 covers the area just below the clavicle.

C5 to T1. These dermatomes are all situated in the arms. C5 covers the lateral arm at and above the elbow. C6 covers the forearm and the radial (thumb) side of the hand. C7 is the middle finger, C8 is the lateral aspects of the hand, and T1 covers the medial side of the forearm.

T2 to T12. The thoracic covers the axillary and chest region. T3 to T12 covers the chest and back to the hip girdle. The nipples are situated in the middle of T4. T10 is situated at the umbilicus. T12 ends just above the hip girdle.

L1 to L5. The cutaneous dermatome representing the hip girdle and groin area is innervated by L1 spinal cord. L2 and 3 cover the front part of the thighs. L4 and L5 cover medial and lateral aspects of the lower leg (British Orthopaedic Association, 2006).

Recognising and treating the early signs and symptoms can avoid the dangerous sequelae of extreme hypertension, i.e. cerebral haemorrhage. The quickest way to treat the symptoms is to relieve the cause of the stimulus; commonly a blocked catheter, full bowel, sores, fractures or any other focus of pain. If the cause cannot be relieved quickly, then a vasodilator needs to be given, such as sublingual glyceryl trinitrate (GTN) spray or nifedipine. These patients can die within five or ten minutes if this is not recognised and treated promptly.

Fixation

Be aware that many patients who are fixed are not always stable and some require refixation in order to secure the desired stability. Fixation is desirable prior to aeromedical transfer, but all of these patients can be moved safely with adequate precautions.

Ascending lesions

Cord oedema at the site of the original injury can cause the neurological level to rise. Patients should not be moved without full support until the neurological level has stabilised; there is a risk that the level may rise further during the transfer and what starts out as a C6 injury could become a C2-3 injury with devastating consequences.

Collars, braces and corsets

Overall, collars, braces and corsets are of little use for patients on flat bed rest. However, they are beneficial for seated patients.

Referral

Studies show that functional independence is optimised by early referral to specialist centres; the gold standard is admission on the day of injury. Early specialist care has been shown to reduce complications such as pressure sores, chest infections, contractures and urinary tract infections. Average stay in a specialist unit is six months for a paraplegic and nine months for a tetraplegic.

Temperature control

There is a loss of temperature control systems below the level of the injury. The body is unable to vasodilate or vasoconstrict to lose or maintain heat by the normal thermoregulation process. Although these systems may still work, they will do so completely independently of the environment: i.e., there may be peripheral vasodilation when it's cold instead of the normal vasoconstriction to preserve heat. Therefore, the higher the level of the lesion, the greater the susceptibility to hyperthermia or hypothermia, both of which can be quite profound. Monitoring of core body temperature is essential in SCIs.

Vacuum mattress

Vacuum mattresses are a perfect insulator and, as such, can prevent heat loss in spinal injury patients who have no thermoregulatory control. It has not been unknown for cervical injuries to arrive at their destination with core temperatures > 40 degrees centigrade after a two-hour

In-flight nursing course

This course, jointly validated by the Faculty of Health and the RCN, is offered by London South Bank University, at Southwark.

Designed and developed for experienced nurses in the repatriation of acutely ill patients, this course is unique in that it provides students with an RCN certificate recognised as the kite mark for in-flight nursing as well as 30 points at level 3 offered by London South Bank University.

Course duration

The duration of the course will be over 15 weeks and constitutes a self-directed component of eight weeks, using e-learning, two weeks' attendance (inclusive of three days of practical experience) and a consolidation period of five weeks. Courses are run once a year, with a maximum of twenty-four students per course to ensure that students can work in small groups and gain the most from the practical sections of the course.

Training

The practical activity days allow students to familiarise themselves with the different types of aircraft and equipment, using major international airports. Training includes evacuating an aircraft in an emergency; a certified fire-fighting course so that the nurse can assist the cabin crew in the event of a fire on board an aircraft; an experiential learning section in a typical emergency scenario on a large aircraft and in an air ambulance set up in a small aircraft.

Course aims

The overall aim of the programme is to prepare competent and reflective flight nurses who adapted their existing nursing skills to practice more competently in the in-flight domain. It highlights situations that require specific knowledge and skills of the in-flight domain, and of the personal safety and health needs of the nurse and patient. As well as covering nursing and medical fields, the course aims to familiarise students with the administrative and legal aspects of national and international air travel. Particular emphasis is placed on the in-flight nurse as an autonomous practitioner, in most instances working alone.

Academic year

- **14 May–6 July 2007** – distance learning using web and e-learning
- **9–20 July 2007** – attendance at London South Bank University
- **23 July–24 August 2007** – period for reflection and completing case study.

Course enquires

For further details, please contact Course Director Mr. Siva Murugiah, telephone: 020 7815 6736, email: murugis@sbu.ac.uk. For application forms, please contact: Lelia Oniri, Course Administrator, In-Flight Nursing Course, RCN Development Centre, South Bank University, Erlang House, 103 Borough Road, London, SE1 0AA, telephone: 020 7815 8127, email: oniril@sbu.ac.uk

journey in a hot ambulance on a vacuum mattress. Although vacuum mattresses provide excellent stability for thoracic or lumbar injuries, they provide little or no stability for cervical injuries. In view of this, there is little benefit in using vacuum mattresses for transferring unstable cervical spine injuries; for this, a spenco mattress is sufficient.

Prognosis

A common urban myth is that complete spinal cord injuries have transected the spinal cord; this is rare and generally only occurs with penetrating injuries, i.e. gunshot wounds, knife wounds and the like. The real cause of the paralysis is cord hypoxia due to crushing forces from the fracture, or subluxation, and subsequent hypoperfusion. This makes predicting a prognosis very difficult and most consultants will not give a definitive prognosis for up to two years post injury.

Quick neuro check

The last normal motor and sensory levels determine the neurological level of a spinal cord injury; these levels may be different (*see figures 1 and 2*).

Sensory

A dermatome is a patch of skin that is innervated by a given spinal cord level. Figure 2 is taken from the American Spinal Injury Association (ASIA) classification manual, obtainable from the ASIA website: www.asia-spinalinjury.org. Each dermatome has a specific point recommended for testing and shown in the figure. After injury, the dermatomes can expand or contract, depending on plasticity of the spinal cord.

Conclusion

This 'rough guide' has been designed as precisely that and is not comprehensive. Books have been written for this and can be seen in the references. I think the main thrust of this piece has been to impress upon the reader that these patients are highly fragile, with risks of many life-threatening complications. Transfer of an acute spinal cord injury should not be undertaken lightly and only with serious risk assessment first.

The National Spinal Injuries Centre at Stoke Mandeville Hospital is currently looking at the feasibility of introducing a specialist retrieval team to transfer these patients, even for a short road journey. I hope this can be of use to the target audience and they will use it as a resource and as a working tool.

Further reading

- Grundy D, Swain A (1996) *ABC of spinal cord injury*, 3rd ed., London: BMJ Publishing Group.
- McDermott M, Toerge J, National Rehabilitation Hospital (1998) *Developing and implementing critical paths in rehabilitation: spinal cord injury pathway*, USA: Communication Skill Builders.
- The British Orthopaedic Association Working Group (2006) *The initial care and transfer of patients with spinal cord injuries*, London: The British Orthopaedic Association.

IFNA survey – spring 2007

IFNA committee members work on behalf of all their members and we always want to hear your views on how we are doing.

This survey is to ask you how you think we may need to change and improve. Please take the time to answer the questions and add any notes you feel necessary, then send your replies, via post or email, to Caroline Carter (details below).

Newsletter

- How regular do you think it should be?
- What (if any) regular features should it have?
- Would you like to contribute to the newsletter? If so, how?
- If you could change one thing about the newsletter, what would it be?
- Would you prefer receiving your newsletter electronically (eg, as an email) rather than a printed version?
Yes No
- If you know any RCN members not receiving the newsletter, but who would like to, please tick this box (please do not provide individual details, but instead recommend that they contact RCN Direct or join online).

Study days

- Where is your preferred venue?
- Do you prefer a weekday or a Saturday?
- How many would you like to see per year?
- What topics you would like to see covered?
- Do you think teaching resuscitation and manual handling is part of the IFNA's role?

- What do you feel is a reasonable cost per study day?
- Should lunch be provided?
- Would you pay for lecture notes if you were unable to attend?

IFNA website

- Do you have access to the Internet?
- What content should be on the IFNA website?
- Have you noticed the website's discussion zone?
- Would you use this discussion zone, or have you already?

IFNA committee

- What do you think are the IFNA's priorities?
- What would you like the IFNA to achieve?
- Would you like to be involved in the IFNA and if so, what would you like to do?

Any other suggestions?

- Please indicate in writing.

All replies to be sent to Caroline Carter, IFNA Secretary, First Floor Flat, 172 Randolph Avenue, Maida Vale, London, W9 1PE, telephone: 020 7624 0132, mobile: 07931 785 343, email: carolinecarter1@tiscali.co.uk



This newsletter is published by the Royal College of Nursing, 20 Cavendish Square, London W1G 0RN.

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