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## Further information

Send contributions for the next issue by 23 January 2009 to the Editor:

Rita Mody  
Email: [ritamody@hotmail.com](mailto:ritamody@hotmail.com)

The law relating to consent over the past few years has changed and has become an everyday concern to health professionals. Jane Lynch tells us more about this important issue.

## Consent and the In-flight nurse

The health professional has an obligation to obtain consent of the patient before they can treat them. If they fail to comply with the rules of consent, the patient may bring a civil claim for financial compensation.

The health professional is also in danger of committing a criminal offence. They will be accountable for their actions, and the complexities of consent leave them vulnerable.

I have often heard the following said:

- “Well, if the patient came into hospital that is implied consent to be treated.”
- “Unless the patient refuses treatment in writing then they are consenting to treatment.”
- “The patient had dementia and therefore lacked capacity to give consent.”
- “The patient was unconscious therefore I can treat them.”

The law does not uphold these views. An unconscious patient implies nothing.

A signature on a consent form does not in itself constitute valid consent. There are a lot of other considerations that must be taken into account such as:

- How old are they?
- Did they have capacity?
- How much information did the health professional give them and did they understand it?

Asking someone else, such as a family member, to sign a consent form does not constitute valid consent.

Health professionals are often left floundering when faced with a patient in

difficult situations. Common dilemmas faced by in-flight nurses transporting patients may include a patient who is in distress, suffering from trauma, a stroke, unconscious or unable to communicate. In these circumstances their capacity to consent to treatment may be hindered.

However, it is important not to make an assumption that the person lacks capacity. Where, for example, a person cannot communicate verbally, they may be able to communicate in some other way such as nodding of the head. The fact that they cannot speak does not necessarily render them incapacitated.

Capacity may fluctuate or may be temporary. What should the in-flight nurse do in these circumstances? Should they wait until capacity returns before treatment or transportation commences or continue with treatment and review the position once capacity returns?

The Mental Capacity Act 2005 sets out core principles together with the new code of practice which must be followed where the patients' capacity is called into question.

**“ A signature on a consent form does not in itself constitute valid consent. There are a lot of other considerations that must be taken into account ... ”**

## Letter from the Editor

The current climate for overseas travel, and especially for airlines, is not looking healthy. Soaring fuel prices mean that already this year, several airlines have ceased business. At the time of writing, Excel are the latest victim with thousands of holidaymakers stranded abroad and there are fears for further airlines in the near future.

As flight nurses, we are even more acutely aware of this climate as it has an effect on our working environment. Over the time I have been flying, there have been many changes in airlines such as increased numbers of low cost carriers, new start-up airlines with less experience of carrying unwell passengers and the more obvious changes in carriage of stretcher patients.

Yet, flight nurses are adaptable and

will continue to work within this environment to ensure the best care for our patients despite all the current changes. Patient safety is key and part of this is knowledge that their oxygen needs in flight will be appropriate. Dr Terry Martin writes in detail on this subject for us on page four.

Alongside this is aircraft safety and many of you will have heard of the decompression incident on the Qantas flight. You may even have been on that flight, or known someone who was. There was a happy ending, with the flight landing safely in Manila. However it does bring home how, not only do you have to contend with all the other logistics of a repatriation, but also the unexpected. Luckily, air travel is still the safest way to fly, and on page seven is a link to a website which shows each airline's safety records.

### On a lighter note

We had another successful study day in July. We had one of the highest numbers

of in-flight nurses and associated parties attending and final numbers were in the 60s. Many of you commented that it was the best yet which is a great achievement!

We will also have a presence at the ITIC conference in Budapest in November, having specifically been requested by the organisers to speak on a flight nurse/repatriation related issue.

So that you do not miss all these important future events – see *Dates for your diary* on page five.

Forums are changing and Alan Steward talks about this in his letter below. We are still a small (but loud!) forum and intend to continue to be your voice within the RCN.

There is lots more in this newsletter, so please enjoy, and as always, if you have any comments, I would love to hear from you.

**Rita Mody**

## Letter from the Chair

I have heard only great things from our July study day and the evaluations reinforce my belief that this forum is driven by individuals who hold the passion of nursing patients in-flight.

I've recently been appointed as the Matron for Emergency Care (formally A&E) in Leeds – a great opportunity and

it will allow me more time to spend on my other commitments, including the IFNA. I am still linking with colleagues at the Extra Corporeal Membrane Oxygenation (ECMO) Centre in Leicester, and offering advice and support around the Adult Retrieval Team.

### A “speedy” recovery

I've had a celebrity-driven year after getting mixed up in the care of Richard Hammond (“The Hamster” on the BBC's Top Gear), who crashed in a dragster-style car capable of reaching speeds of about 300mph at Elvington Airfield near York. I didn't get a publishing deal, but I did end up in his book and have been to a hospital-led party to celebrate his survival. I also got to see the filming of Top Gear. All very impressive and exciting!

The forum is doing well and the committee members continue to show a great deal of enthusiasm. We are looking this year at re-engaging with our colleagues in defence nursing. We will also be reviewing the competencies and have managed to get a seat around the table of a discussion about advanced practice – something close to all our hearts I know.

### Restructuring update

You may be aware of the planned

rationalisation of the forums. The consultation to reduce the overall number of forums has been ongoing for over a year and I understand a statement will be made by the RCN in due course.

The IFNA has been aligned to the Critical Care Forum, an interesting choice and we have to see this as a positive move. The committee will be meeting in September to discuss this decision. Meanwhile, I have started to look at how we will sit with the Critical Care Forum and made initial contacts. I was previously in this forum while a senior nurse in intensive care.

The IFNA Committee will remain as follows for the foreseeable future.

**Mark Payne** – elected until 2010

**Caroline Carter** – elected until 2008

**Rita Mody** – elected until 2008

**Ryan McNay** – co-opted until 2008

**Rachael Leader** – co-opted until 2008

**Alan Sheward (Chair)** – co-opted until 2008

**Catherine Gates** – co-opted until 2008

Owing to the current Professional Nursing Department restructure, it was decided to hold a transitional period rather than elections. Elections will take place in 2009.

**Alan Sheward**

RCN Fertility Nurses Group Conference & Exhibition

## Regulation – rest assured

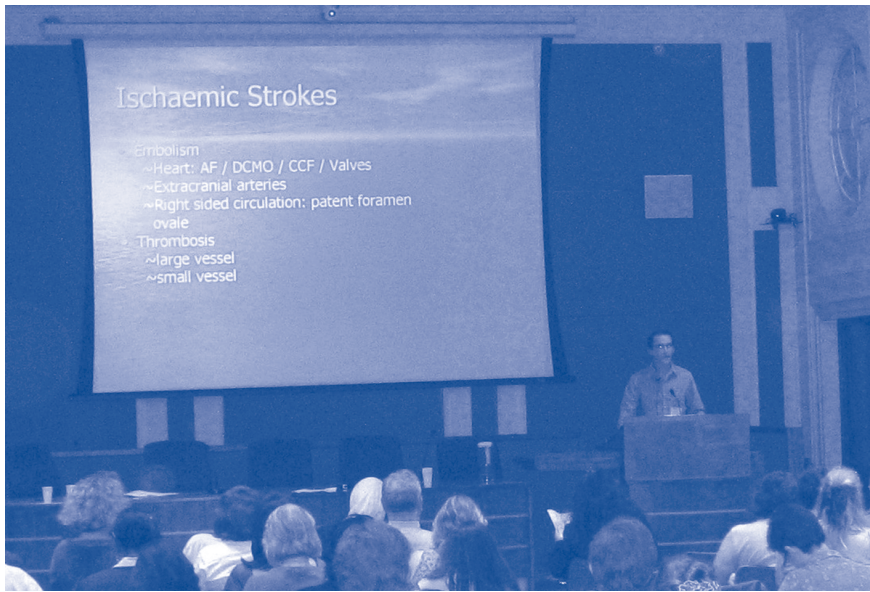
Saturday 7 February 2009  
Royal College of Nursing  
20 Cavendish Square, London W1G 0RN

This leading conference is designed to ensure that nurses working the in the areas of fertility, women's health and general practice are aware of the relevant regulations and legislation, and are meeting these requirements in practice.

For more information contact  
Pat Anslow on 029 2054 6492  
Email [pat.anslow@rcn.org.uk](mailto:pat.anslow@rcn.org.uk)  
[www.rcn.org.uk/events](http://www.rcn.org.uk/events)

From  
Just  
£105

# A great turnout for a great day!



As always, Caroline Carter did an excellent job of organising the IFNA study day on 12 July. She makes it look easy, but spends hours arranging all the behind-the-scenes activity to make sure it's worthwhile giving up your Saturday with John Lewis so tantalisingly near!

We know it is not always easy for self-employed nurses to attend so in case you missed it, we're hoping to get permission to put some of the lectures onto the website.

Thanks to those who attended for completing evaluation forms – this

really does help us decide what works and what doesn't.

Here are a few of your comments:

- Good variety of useful lectures with experienced people giving them.
- Superb, great value for money, enjoyable and very useful.
- Excellent update on current developments with IFNA study dates plus contact emails information.
- First time to attend – I feel I have learned a lot. I am also curious about what goes on in in-flight nursing, well presented.

Expert witness skills:

- Who would have thought the law could be so humorous! Very well delivered.
- Well presented with very good examples; good topic to assist all professionals when called as witnesses in court.

Paediatric transfers:

- Fascinating – good to have this although I would probably never do a paed Tx. Please keep these “specialist” lectures.
- Excellent – not my speciality but loved the educational aspect.

Passengers with medical problems:

- Stressed need to assess patient's problems well before flying them.
- Interesting, informative plus funny. Please keep contact with airline lecturers.
- Very good view from the industry.

**Heathrow 's Terminal 5 has been handling passengers for over five months and the news stories regarding initial problems have died down. However, one flight nurse makes us aware that not all is problem-free.**

## T5 revisited

“I recently arrived from Nice to LHR T2 and had to wait an hour for a wheelchair and accompanying airport personnel. A member of staff eventually arrived who had started in the job only the week prior. He took us to T5 on the bus. On arrival at T5, it was apparent he did not know where to go (and during our conversations admitted he had only been there once before).

“However, it seems he was not the only one as when he asked five people how to get to the BA lounge, all gave different directions.

“Eventually we were taken through a security-swipe door where the public are not allowed and, in doing so, missed passport control, immigration and security.

“A much more experienced wheelchair assistant came to pick us up from the BA lounge and took us to the gate for next flight to Manchester. It was only then realised that we had missed security – which is a massive breach of security in itself!

“The Team Leader and Manager of T5 were eventually called to sort the problem out and we had to re-trace our steps so that we could all be taken through security (at the other end of the terminal).

“We were finally escorted onto the flight an hour late!

“Needless to say, it caused an awful lot of unnecessary stress to a previously hospitalised patient as well as causing security issues which could have been avoided, had the proper training taken place.”

## Did you know you can read this newsletter online?

**This and other forum newsletters are available on the RCN website even before they are mailed out to members.**

So if you would like to be one of the first to read the next issue log on to **MyRCN** at [www.rcn.org.uk/myrcn](http://www.rcn.org.uk/myrcn), or call RCN Direct on **0845 772 6100**, to register your email address and opt in to our email services. You'll then be sent an email with a link through to the newsletter each time it is published.

**Help us reduce our carbon footprint and save some trees!**

Here's some potentially life-saving guidance from Dr TERRY MARTIN, Consultant Intensivist/Anaesthetist and Director, CCAT Aeromedical Training.

# In flight, how much oxygen is 'enough'?

The simple answer is, the amount needed to maintain normal activity of the cells without temporary or permanent damage. But the answer during aeromedical transport is a little more complex.

Few would disagree that oxygen is the first "drug" of choice in any medical emergency and nowhere is this more true than in an aircraft cabin where reduced ambient pressure means that fewer oxygen molecules are available for physiological use and they are dispersed in a larger volume.

However, the key is *prevention* – the best transfer is the one where problems are anticipated so that no interventions are required in the out-of-hospital environment.

## So, how much is "enough"?

Calculating oxygen requirements for patients causes a lot of concern and rightly so. Get it wrong and the patient may suffer the ill effects of hypoxia for all or part of the transfer. I can't cover all eventualities here, but a few points will help decision making.

First, though, there are a few key facts that are essential background knowledge for aeromedical personnel:

### 1. The fundamentals of altitude physiology

- The proportions of gases in the mixture known as "air"
- The relationship between altitude and air pressure
- Boyle's and Dalton's laws
- How the partial pressure of available oxygen in air varies with ambient pressure
- How the oxygen cascade varies with altitude
- The four major types of hypoxia
- The respiratory and cardiovascular effects of hypoxia
- The neurological effects of hypoxia.

### 2. The oxygen dissociation curve

- Interpretation of the curve and its importance in ill patients
- The causes and importance of curve shifts
- How the curve is affected by altitude

- How the curve is affected by acute and chronic anaemia.

### 3. An understanding of oxygen-related measurements

- The definitions of oxygen content (CaO<sub>2</sub>), saturation (SpO<sub>2</sub>) and partial

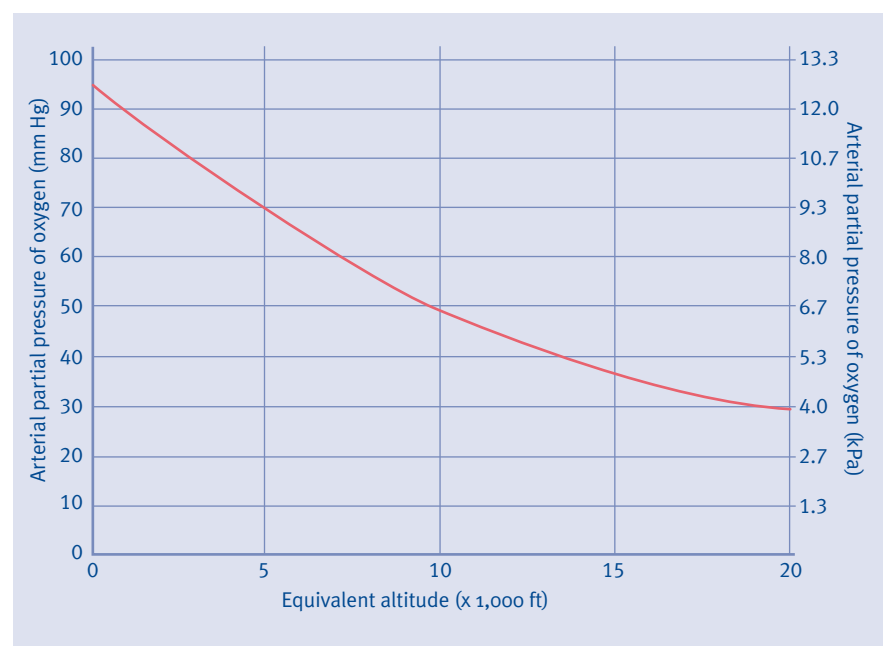


Figure 1: Arterial PO<sub>2</sub> up to 20,000 ft (6,096 m), breathing air

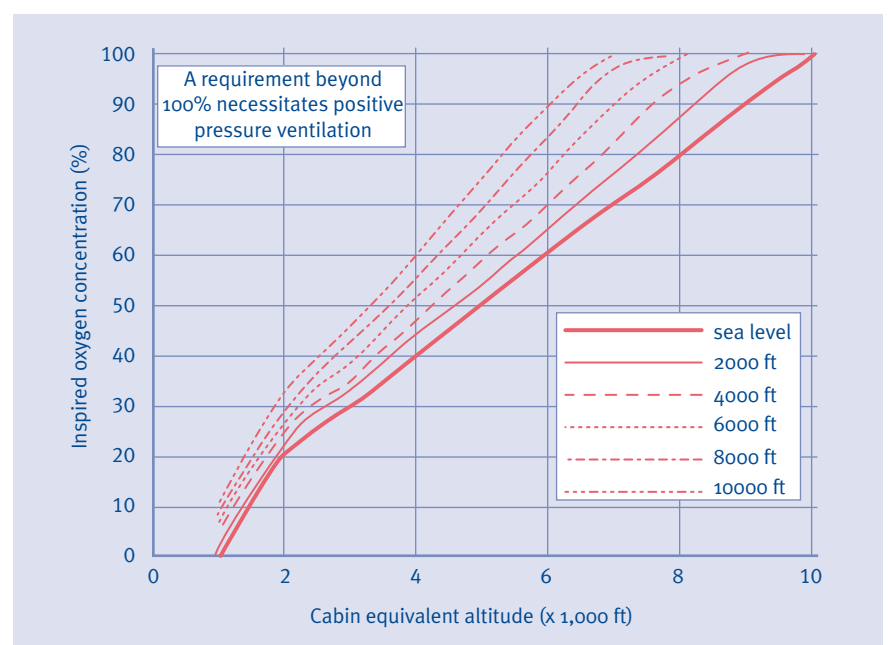


Figure 2: The fractional concentration of oxygen required in the inspired gas to maintain alveolar PO<sub>2</sub> of 13.3 kPa (100 mmHg)

## Dates for your diary

### RCN Travel Health Forum Conference and Exhibition

25 September 2008

Royal College of Physicians, London  
Contact: [www.rcn.org.uk/events](http://www.rcn.org.uk/events)

### IATA Cabin Health Conference

International Air Transport  
Association (includes 3rd Aviation  
Health Conference)

1–2 October 2008

Geneva

Contact:

[www.iata.org/events/cabin-health](http://www.iata.org/events/cabin-health)

### 16th International Travel Insurance Conference

10–14 November 2008

Budapest

Contact: [www.itic.org.uk/budapest](http://www.itic.org.uk/budapest)

### 2nd International Symposium on Air Travel and Health

Aerospace Medical Association

20–22 November 2008

Dead Sea, Israel

Contact:

[www.palexconventions.co.il/ath2008](http://www.palexconventions.co.il/ath2008)

### In Flight Nurses Association (IFNA) dates

#### Study Day

Saturday, 15 November 2008

#### 2009 Study Days

Friday, 6 March (ILS) (Cowdray  
Hall, Council Room and 106/107)

Saturday, 11 July (Cowdray Hall and  
Council Room)

Saturday, 14 November (as above)

#### Committee Meetings

Friday, 5 December 2008 –  
3.30–5pm teleconference

#### Committee Meetings 2009

All on Fridays, 11am–4pm

● 13 February

● 15 May

● 4 September

● 4 December – 3.30–5pm  
teleconference

#### RCN In Flight Nursing Course

London Southbank University

Starts May 2009 – 15 week course

Details at:

<http://prospectus.lsbu.ac.uk>

pressure (PaO<sub>2</sub>), and inspired oxygen fraction (FiO<sub>2</sub>)

- The physiological relationship between haemoglobin (Hb), SpO<sub>2</sub> and PaO<sub>2</sub>
- The limitations of pulse oximetry
- The value of blood gas analysis.

You will have studied this material during the IFNA or CCAT courses, but have you ever put the theory into practice? The issue is really about matching oxygen requirements to the patient's pathophysiology, but with the added complexity of accounting for the hostile environment in the aircraft cabin. If your memory of any of these topics is vague, spend some time perusing the "further reading" list.

### The key point to bear in mind

If you know the patient's *oxygen status* when in a well oxygenated and stable condition on the ground before take-off, simply aim to replicate that status.

So what do I mean by "oxygen status"? This is combined knowledge of the Hb, FiO<sub>2</sub>, PaO<sub>2</sub> and SpO<sub>2</sub>. Not all patients will have this information available prior to their transfer and, clearly, not all will need it. However, seriously ill patients will have higher oxygen demands because of their pathology and/or treatment. I therefore believe that the new hand-held blood gas analysers will become essential equipment for the assessment of aeromedical patients prior to departure and also en route.

With knowledge of the ground level oxygen status data, the aim is to maintain minimum PaO<sub>2</sub> at that ground level equivalent, probably in the range 10.7–13.3 kPa.

Using figure 1, the patient's PaO<sub>2</sub> can be used to find the equivalent altitude. If the patient's location is significantly *higher* than sea level, the height should be *deducted* from this equivalent altitude. The resultant final figure (the sea level compensated equivalent altitude) is plotted on figure 2 against the actual cabin equivalent altitude to give the fractional inspired oxygen needed to maintain a PaO<sub>2</sub> of 13.3 kPa in flight.

Once the flow rate required to maintain an adequate FiO<sub>2</sub> and PaO<sub>2</sub> is known,

you can determine the volume of oxygen required. For instance, if a constant flow of five litres per minute is required and the full oxygen cylinder contains 680 L (E size cylinder), then the contents will last for no more than 136 minutes. (Note: in practice, the effects of Boyle's Law on the cylinder gas can be ignored at cabin altitudes up to 8,000 feet.)

Although the ventilation of ICU patients is more complex at altitude, their oxygen requirements are easier to estimate accurately. That is, (Minute volume x FiO<sub>2</sub> x estimated transfer time in minutes) / cylinder capacity.

Remember also that some ventilators are gas driven and you must know how much oxygen is diverted for that purpose (usually around 20 ml/min).

Clearly, less oxygen will be needed for Pulse Dose Oxygen systems, but the key is to carry more than you think will be needed so that allowances are made for unforeseen delays and deterioration in the patient with subsequent increase in oxygen demand. It is wise, therefore, to take a 100 per cent reserve.

### Why not 100 per cent throughout the journey?

Quite simply, as well as being uneconomical and incurring the weight penalty of unnecessary cylinders, 100 per cent inspired oxygen over long periods is an irritant, may be toxic to the respiratory tract and may contribute to delayed otic barotraumas.

So having elected to use supplemental oxygen in flight, clinical acumen and an understanding of the symptoms and signs of hypoxia are your best guide. Medical crew must always err on the side of caution. Constant reappraisal of the patient is essential and inspired oxygen should be titrated to match clinical and monitored responses.

#### Further reading

Martin, TE (2003) Clinical and practical aspects of aeromedical transport, *Current Anaesthesia & Critical Care*, 14, pp. 131–148.

British Thoracic Society (2008) Managing passengers with respiratory disease. Available from: [www.brit-thoracic.org.uk](http://www.brit-thoracic.org.uk) (Accessed 15 August 2008) (Internet).

# Mandatory Electronic System for Travel Authorisation (ESTA)

As you may have recently seen in the news, from 12 January 2009, the American Department of Homeland Security will implement a **mandatory** Electronic System for Travel Authorisation – the ESTA – for visitors from countries currently part of the American Visa Waiver Program (VWP).

## This includes UK passport holders

Nationals of countries which are part of the VWP will need to apply online for clearance to travel to the United States before they fly. The new ESTA system will process visa applications against law enforcement and immigration databases to screen for potential threats to the United States. Please see below the main points at present:

- Although it is not mandatory until 12 January 2009, ESTA applications can already be made voluntarily.
- If an ESTA application is approved, it is valid for multiple entries into the United States. An ESTA is valid for up to two years, or until the traveller's passport expires if sooner.
- Please note that although an ESTA is necessary, it does not guarantee admission into the United States at the port of entry. An ESTA only authorises a traveller to board an air or sea carrier to travel to the United States. The final decision to authorise entry will be made by US Customs and Border Protection (CBP) at the port of entry.

For more details, visit <https://esta.cbp.dhs.gov>



## The RCN Research Society is proud to invite you to **Winifred Raphael Memorial Lecture 2008**

**VENUE:**  
The Research Beehive,  
Newcastle University,  
Newcastle-upon-Tyne

**TIME:**  
5.30–6.30pm

**DATE:**  
Tuesday 25 November  
2008

**All Welcome  
Free Admission**

Drinks and Nibbles  
Reception From 4.30pm

**Speaker: Professor Karen Cox**

**Title: "Clinical Trials and Clinical Research in Cancer. A Nursing Perspective"**

Professor Karen Cox is Professor in Cancer and Palliative Care at the University of Nottingham School of Nursing. Karen graduated from Kings College London University in 1991 and has worked in a variety of acute and community clinical settings. She completed her PhD at the University of Nottingham in 1999 and was promoted to a personal chair in Cancer and Palliative Care in 2002. Her research is concerned with psychosocial aspects of clinical trial participation and supportive aspects of cancer care and its treatments.

**Please email Jenny Peters to register your attendance:**  
[boltonr&dtemp@rcn.org.uk](mailto:boltonr&dtemp@rcn.org.uk)

### CONTINUED FROM PAGE ONE

Capacity is both time and decision specific. As a rule, most people will be able to make most decisions most of the time. A lack of capacity can change over time; a person may have the capacity to make some decisions but not others.

The law of consent is not simple to interpret and apply so it is hardly surprising that consent is often inadvertently misunderstood or misapplied by health professionals.

Legal claims relating to consent issues are increasing. Often claims arise because of a lack of understanding by the health professionals of the law and principles relating to consent.

Sadly, many claims are also brought because there is no evidence from the records that valid consent was obtained.

Standard consent forms are often not explicit enough. A good standard of record keeping will avoid this situation but the health professional must be fully conversant with the issues of consent in order to make an appropriate entry in the records.

If the health professional fails to obtain valid consent, the health professional will be accountable to, amongst others, the patient, their employer and professional body. Health professionals have an obligation to keep abreast of the law relating to their areas of practice and would be well advised to ensure a good knowledge of the issues of consent.

**Jane Lynch is a lawyer and the director of the Practical Legal Training Agency providing medico-legal training for the health sector. For further information on consent training and other courses contact [info@plta.co.uk](mailto:info@plta.co.uk) or [www.plta.co.uk](http://www.plta.co.uk)**



**RCN EVENTS**  
[www.rcn.org.uk/events](http://www.rcn.org.uk/events)

## Renal care across communities

A series of workshops on renal disease and care management

**London – RCN HQ, London Thursday 30 October 2008**

**Belfast – RCN Northern Ireland Thursday 4 December 2008**

Workshop  
fee only  
**£25!**

## NEWSROUND

**Feeling the pressure?**

Flyglobespan, the budget airline, is to be prosecuted after allowing a 757 jet to fly "illegally" to America with faulty instruments. It's the first criminal prosecution against a British airline for more than a decade.

The 12-year-old Boeing 757 was flying between Liverpool, Knock and New York on 28 June last year when both engine pressure ratio gauges failed as the jet took off from JFK. The pilot reported the faults when he reached Liverpool.

The plane should have been grounded until at least one of the gauges had been fixed, but the airline authorised it to fly back across the Atlantic with neither gauge functioning.

Source: [www.timesonline.co.uk](http://www.timesonline.co.uk) (25 May 2008)

**Damned if you treat, damned if you don't**

The UK Government recognised the need for standardisation in the adventure travel market in this year's BS8848 document, covering the need to provide medical support by a recognised medical practitioner. All was well until the implications of providing medical cover to Americans, among others, was highlighted.

Defence unions advise that although doctors are covered to treat Americans, they are not covered for court cases that arise in North America (Americans can sue a doctor there, independent of where the treatment occurred). The General Medical Council advises doctors not to participate in activities without appropriate cover.

However, if a doctor does not treat an American on an expedition, the American participant can sue for racial discrimination and report the doctor to the GMC for improper conduct.

Source: Sean T Hudson, Medical Director, Expedition Medicine ([sean@expeditionmedicine.co.uk](mailto:sean@expeditionmedicine.co.uk)) in a letter to the BMJ – [www.bmj.com/cgi/content/extract/335/7624/788](http://www.bmj.com/cgi/content/extract/335/7624/788)

**Show Business Class!**

CelebAir is a real airline, flying to real destinations with real passengers – but with a very special celebrity service.

An exclusive group of passengers will be able to travel while celebrities work as airline staff on this unique showbiz airline. CelebAir will have its own check-in desk at London Gatwick, its own planes, its own tickets and its own dedicated staff of celebrities trained to the highest standards of air travel. Then tune in and watch the results on an ITV2 reality show this autumn.

Source: [www.flymonarch.co.uk](http://www.flymonarch.co.uk)

**Plane humour**

Taxiing down the tarmac, the jetliner abruptly stopped, turned around and returned to the gate. After an hour-long wait, it finally took off.

A concerned passenger asked the flight attendant: "What was the problem?"

"The pilot was bothered by a noise he heard in the engine," she explained, "and it took us a while to find a new pilot."

**e-RESOURCES****[www.caa.co.uk/fitnesstofly](http://www.caa.co.uk/fitnesstofly)**

This Civil Aviation Authority guide provides information to medical personnel on patient fitness to fly.

**[www.iata.org/ps/publications/9371.htm](http://www.iata.org/ps/publications/9371.htm)**

The IATA medical manual brings together the experience of medical directors from airlines, university faculties, travel medicine training, health organisations and government authorities worldwide.

**[www.who.int/ith/en](http://www.who.int/ith/en)**

WHO's 2008 report provides information on the main health risks for travellers.

**[www.airsafe.com](http://www.airsafe.com)**

This website reports on events involving airline passengers by airline and aircraft model, plus current aviation safety issues.

**IFNA online community goes live on the RCN website**

During a lengthy period of change to RCN forums, one aspect of restructuring has been to ensure all forums have a "voice" on the RCN main website. This meant that our external IFNA website had to be discontinued and re-aligned with [www.rcn.org.uk](http://www.rcn.org.uk)

We are pleased to announce that the In Flight Nurses online community is now up and running – check it out via links on the RCN home page or fly direct to: [www.rcn.org.uk/inflight](http://www.rcn.org.uk/inflight)

The community has many features, including a clinical section, bursary information and an interactive area where you can contribute through the Discussion Zone and *Have your say*. We will continue to update this site so that it is a useful "live" resource to you.

VAL PITMAN reports.

# The case for 'door-to-door' delivery: a cautionary tale!

In February I flew out to France to bring back a 22-year-old man who had been in a snow boarding accident. He was a week down the line, having spent most of that time in a large university hospital.

John (not his real name) had sustained a stable fracture to his C1 and C6 vertebrae and unstable fractures to C4 and C5. His unstable vertebrae were surgically treated with an arthrodesis and he was making a good recovery. Other than a bit of tingling in his right thumb and index finger he was neurologically intact – lucky chap indeed! The only future management was to spend the next three months in a wide soft collar.

The plan was to fly home seated as he was able to sit for a couple of hours with no problems, but have a stretcher for the road journeys, particularly necessary for the UK side as his home was nearly four hours away from Gatwick.

All went well. I gave him his prescribed oral analgesia and anti-inflammatory medication, and we had an uneventful trip back to his parents' house. There was an emotional reception from his parents and two sisters, welcome home banners festooned the cottage and the kettle was on.

## My parting advice ...

Over a cup of tea I handed over the rather sparse report and the wad of CT scans I had managed to obtain. I advised that John should be followed up by a neurosurgeon as soon as it could be arranged and that the best way would be to get himself referred through his GP.

This was now Friday night and his father said that he had already arranged for John to be checked over on Monday morning.

I felt happy with that and, apart from saying that should John experience any problems over the weekend they should take him straight to an A&E, there would be nothing further I could do.

A week later imagine my shock when John phoned me to say that he was in a spinal unit having just had further surgery! The very switched on GP he had seen on the Monday morning had spotted something on the CT scan and arranged an urgent appointment with a neurosurgeon. A further scan revealed an unstable C7 fracture!

## Several things have since passed through my mind

I telephoned the assistance company and spoke to one of the most experienced nurses there. Like me she was shocked, but we were both at a loss to know what else we could have done.

Should we send doctors on all spinal injury repats? Would all of them be able to read CT scans? Probably not. A French university hospital is probably one of the better places to be following a trauma and therefore we trust them to investigate and treat fully. So how are we to know if this hasn't been the case?

The other awful thought I had was this.

Most of the assistance companies I work for do not have the policy to accompany the patient to their final destination, be it home or hospital. In this particular case the company did. I've started to think that perhaps we should always stay with the patients. What if I had handed John over to an ambulance crew and they mishandled him because they had no understanding of spinal injuries? Let's face it, many private companies do not

employ fully qualified crews. How would I have felt if a wrong movement had affected the undetected fracture and John had ended up partially paralysed?

## Going the distance

Knowing we can hand over patients at the airport often raises the question: Would I go with the patient if he was going 20 miles down the road? If the answer is yes, then that should also be the case for 200 miles!

Setting a new precedent to always accompany the patient would have enormous implications, particularly regarding costs. Over-nighting far more often in places like Manchester and Glasgow, for example ... enormous added expenses. The underwriters would object but, finally, patient safety is surely the main concern and if we make it a policy that we deliver a "door-to-door" service then we would never have to face an "if only" situation!

PS. John continues to make slow but steady progress. As I write he is doing very well.

## Plane humour

As their time to migrate approached, two elderly vultures doubted they could make the trip south so they decided to fly "airline."

When they checked their baggage, the staff at the check-in noticed that they were carrying two dead raccoons. "Do you wish to check the raccoons through as luggage?" she asked.

"No, thanks," replied the vultures. "They're carrion."



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