

IN FLIGHT NURSING NEWS

www.rcn.org.uk/inflight

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Letter from the Editor

Careful – you might get what you wish for!

I take it all back. Since the last newsletter when I bemoaned the lack of work, I seem to have spent very little time doing anything but! I just hope that you've all been as busy as you need to be as well.

However, although the quantity is there, the quality lacks, with plenty of night flights, impossibly early starts, long road transfers etc. It's the nature of the beast these days, but it's not work for the faint-hearted!

In this issue

Unlike myself, who whiles away the outbound flights flicking through *Hello* magazine and indulging my latest craze for Sudoku, Mark Jarratt uses the time far more productively, as he reports on page six. I am seriously considering following his example.

And many thanks to the Travel Health Forum, and in particular to Sandra Grieve and Jane Chiodini, for allowing use of their article on the Green Book (see page two), which gives invaluable information on the most recent travel vaccination recommendations. Many of you have experience in this area and so will be well aware of the frequent changes that are

made in immunisation advice and technique. This feature offers information about the more common travel vaccinations, along with useful website addresses.

Study days

We had a great study day on 15 July, and well done to Caroline for bringing it all together, yet again. There was a good turn-out and the lectures were all well received. Thanks to all of you who attended – I hope you found it worthwhile. Your feedback forms are incredibly helpful to us when we're deciding what subjects to cover, so please keep taking the time to fill them in with your comments (good and bad!).

We are in the planning stages of the next event – watch this space for details. Look out for this as it promises to be a stimulating event.

Val Pitman

Further information

Send contributions for the next issue by 8 January 2007 to the Editor:

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STOP PRESS!

Luggage restrictions cause airport chaos

Due to all airports recently being put on 'critical alert' (downgraded to 'severe' at time of going to press), we await further developments to see how added security measures will affect our industry.

No doubt there could be enormous implications regarding hand luggage, in effect, the 'tools of our trade', but it is too early to expect the assistance companies to

have any answers. They are, however, working with both the airport authorities and government departments to clarify the limitations on carriage of essential medical equipment for use with patients. While these restrictions are currently affecting UK flights, the impact in other countries, and in the longer term, is as yet unknown.

At time of going to press,

IFNA has been made aware that most patients are being kept overseas until such a time when it is possible to transfer them with minimal delay. We will post the latest developments on this and other related issues at www.rcn-ifna.org.uk

In the meantime, if anyone has any ideas, or wants to let us know of any experiences they have had, please send them in.

Immunisation against Infectious

From an article by SANDRA GRIEVE and JANE CHIODINI for RCN Travel Health Forum's newsletter.

The information given in this summary is brief and points highlighted are selected in relation to everyday travel medicine practice. It must be stressed that it should be read in conjunction with the new draft chapters currently available on the Internet at: www.dh.gov.uk. This summary was current at the time of writing, but please be aware that, although these chapters have been signed off by the Joint Committee on Vaccination and Immunisation (JCVI), they will be subject to sub-editorial changes when published as a complete volume.

General information that relates to many chapters of the Green Book

- **For all disease chapters.** Excellent information about the disease, history and epidemiology, vaccines and so on.
- **In most chapters,** states 'vaccine can be given at the same time as other vaccines and should be given in a separate site, preferably in a different limb. If given in the same limb, they should be given at least 2.5cm apart.'
- The following is detailed **in the introduction of chapter five**, but applies throughout the book: recommendations on immunisation procedures are based on currently available evidence and experience of best practice. In some circumstances, this advice may differ from that in the vaccine manufacturers' Summary of Products Characteristics (SPC). When this occurs, the recommendations in the Green Book are based on current expert advice received from the JCVI and should be followed. These Green Book recommendations and/or further advice in the Chief Medical Officer (CMO) letters and updates and/or in the NHS Purchasing Supply Agency's Vaccine Update should be reflected in local protocols and Patient Groups Directions (PGDs).

Chapter 4: storage, distribution and disposal of vaccines

- Greater importance is given to having one trained individual with at least one trained deputy, responsible for receipt and storage of vaccines and recording of refrigerator temperatures.
- Ordinary domestic refrigerators must not be used.
- All vaccines are POMs and must be stored under locked conditions.
- Calibration of thermometers should be checked annually.

- An approved cool box from a recognised medical supply company should be used to store vaccines during defrosting and so on.
- Surgeries should have no more than two to four weeks' supply of vaccines at any time. Best practice is to order smaller quantities on a regular, scheduled basis.
- Sharps containers should be replaced once two-thirds full and should not be accessible to any unauthorised individual.

Chapter 5: immunisation procedures

- Specified training in immunisation must be received.
- IM injection: the needle length needs to be sufficiently long to ensure the vaccine is injected into the muscle.
- 25mm (1 inch) is preferable and is suitable for all ages.
- For older babies, children and adults, a 23G needle is recommended.
- It's not necessary to aspirate the syringe after the needle is introduced into the muscle.
- Recipients of any vaccine should be observed for immediate adverse reactions. There is no evidence to support the practice of keeping the patients under longer observation in the surgery.

Chapter 6: immunisation by nurses and other health care professionals

- This chapter summarises Patient Specific Directions (PSDs) and Patient Group Directions (PGDs), as neither was in place when the 1996 edition of the book was written.

Chapter 16: cholera

- Detail about cholera vaccine (Dukoral) licensed in UK since May 2004, which is administered orally, a thiomersal-free inactivated vaccine. Guidance for administration is in the new chapter, in written form along with a diagrammatic format.

Chapter 18: hepatitis A

- Four monovalent vaccines; all are thiomersal free and all can be used interchangeably.
- HNIG is no longer recommended for travel prophylaxis.
- Recommended for those aged one year and over who are travelling to areas of moderate or high endemicity – examples given.
- For travellers, vaccine would be given preferably at least two weeks before departure, but can be given up to the day of departure. Although antibodies may not be detectable

Diseases (or the ‘Green Book’)

for 12–15 days following administration of monovalent hepatitis A vaccine, the vaccine may provide some protection before antibodies can be detected using current assays.

- A booster dose of hepatitis A vaccine should be given at six to 12 months after the initial dose. This results in a substantial increase in the antibody titre and will give immunity beyond ten years. Until further evidence is available on persistence of protective immunity, a further booster at 20 years is indicated for those at ongoing risk.
- Ideally, the manufacturers’ recommended timing for the administration of the booster dose of hepatitis A vaccine should be followed, but studies have shown that successful boosting can occur even when the second dose is delayed for several years, so a course does not need to be re-started.

Chapter 19: hepatitis B

- Recommends that people who place themselves at risk by travelling to or going to reside in areas of **high or intermediate prevalence** when abroad should be offered immunisation.
- Different hepatitis B vaccine products can be used to complete a primary immunisation course or, where indicated, as a booster in individuals who have previously received another hepatitis B vaccine.
- Dosages and schedules are documented in the new chapter, which also states there is a new extension to the product license for Engerix B to allow for a very rapid immunisation schedule given at 0, 7 and 21 days with a booster at 12 months. Although not licensed for this age group, this schedule can be used in those aged 16–18 years where it is important to provide rapid protection and to maximise compliance.
- Individuals at continuing risk of infection should be offered a **single** booster dose of vaccine **once only**, at around five years after primary immunisation. Measurement of anti-HBs levels is not required before or after this dose.
- Except in certain groups, testing for anti-HBs is not recommended. The exceptions are those at risk from occupational exposure and patients with renal failure.
- Boosters should be offered to any haemodialysis patients intending to visit countries with a high endemicity of hepatitis B, who have previously responded to the vaccine.
- Valuable information regarding checking the antibody titre for those at occupational risk is detailed and should be read in full.

Chapter 21: Japanese encephalitis

- Two unlicensed vaccines are available in the UK: JE-Vax and Green Cross. Both have similar schedules for rapid and normal vaccination.
- Recommended schedule is 1.0 ml in those three years of age and older, on days 0, 7–14 and 28–30 days, with immunity taking up to a month to develop.
- In exceptional circumstances, when time constraints precludes the course over one month, a two-dose schedule at 0 and 7–14 days, or three doses at 0, 7 and 14 days. These shortened courses may result in lower antibody titres and shorter duration of persistence of antibody.
- JE-Vax boosters are given at two-year intervals; for Green Cross a booster is given one year later and then at three-year intervals.
- Precautions need to be taken in giving the vaccine to those with pre-existing allergies (for example, asthma, allergic rhinitis, drug, food, gelatine or bee sting allergy) and neurological conditions. In the latter group, JE-Vax is recommended rather than Green Cross.
- Ideally, travel should be delayed until ten days after receiving the last dose of the vaccine or travellers should remain in an area with ready access to hospital care.

Chapter 22: measles (summarised just for the travel element)

- Infants from six months of age travelling to measles-endemic areas or to an area where there is a current outbreak, should receive MMR. As the response to MMR in infants is sub-optimal where the vaccine has been given before 12 months of age, immunisation with two further doses of MMR should be given at the recommended ages.
- Children who are travelling who have received one dose of MMR at the routine age, should have the second dose brought forward to at least one month after the first.
- If the child is under 18 months of age when the second dose is given, then the routine pre-school booster (a third dose) should be given in order to ensure full protection.
- MMR is recommended to be given **four weeks apart** from other live vaccines or at the same time.

Chapter 23: meningococcal

- Two vaccines now available: Men C vaccine and quadrivalent ACWY vaccine. Men A/C vaccine is no longer available. Both vaccines are thiomersal free and are inactivated.
- ACWY: two doses for age over three months and under two years, over two years one dose; revaccination is not specified.

Chapter 28: rabies

- Two licensed rabies vaccines are for use in the UK, both inactivated, thiomersal free and interchangeable pre- or post-exposure.
- The JCVI recommends that the IM route rather than the ID route is used.
- For primary pre-exposure immunisation, three doses of 1.0ml rabies should be given on days 0, 7 and 28. The third dose can be given from day 21 if there is insufficient time before travel. For those at regular and continuous risk, a single reinforcing dose of vaccine is given one year after primary dose. Further doses at three- to five-yearly intervals thereafter. For those at intermittent risk, or those revisiting infected areas, a booster dose should be given from two years after primary course.
- Post-exposure prophylaxis now specifies days and timings of recommended vaccine.
- Rabies vaccine and HRIG for use in post-exposure treatment is available free of charge to patients.
- Contact details are provided for all four UK countries.

Chapter 34: typhoid

- Vi polysaccharide vaccine was the only vaccine available in the UK at the time this online chapter was written. However, oral typhoid vaccine is now available again – Vivotif is available from MASTA.

Chapter 36: yellow fever

- YF should not be administered to infants aged five months and under. Those aged six-nine months should only be immunised if the risk of yellow fever during travel is unavoidable; expert opinion should be sought in these situations.
- For people over 60 years of age, the risk for neurological and viscerotropic adverse events increases with age. The risk assessment needs to take account of this.
- Adverse reactions occur in 10–30 per cent of recipients. Systemic side effects can occur early but may last up to two weeks.
- Since 2001, a pattern of neurological adverse events was recognised that occurred in older individuals – now termed yellow fever vaccine associated neurological disease. This was first described in 2001 and is a newly recognised syndrome of fever and multi-organ failure. Some 17 per cent of those with this condition have been reported as having a thymus disorder and therefore yellow fever vaccine is contraindicated in such people.

See information on www.nathnac.org to supplement this chapter. New chapters in the Green Book can be found at: www.tinyurl.com/7ek9m

Professional Membership Structure

Following a very positive meeting of the Professional Membership Structure Action Group (PMSAG) on July 13 a number of significant steps have taken place to develop the RCN's new professional membership structure. The elected members of the group – representing forums and other membership groups – along with the Council and staff leads agreed to set up and support a number of work streams.

The professional membership project aims to get more members involved with the RCN and to enable more equity and access to the RCN's services – services which are designed to meet your needs as a member of the nursing profession. The project will involve making changes to the existing membership structure. RCN Council, at its February 2006 meeting, gave the green light to start the process.

Taking account of members' views expressed at Congress the PMSAG clarified the original proposals and terms of reference for the Action Group as follows:

- in future members will join "divisions" as well as branches
- there will be a maximum of eight divisions
- forums will not be moved into divisions and will retain their national identity, working across divisions as and when appropriate
- networks will be developed as appropriate
- the new structures will be implemented from 2008.

The terms of reference for the Action Group were agreed as:

1. To determine future organisational arrangements for forums and fields of practice
2. To establish the proposed divisional structure
3. To develop criteria for the proposed networks
4. To develop appropriate governance structures for divisions, forums and fields of practice
5. To establish subgroups and work-streams to undertake specific delegated tasks.
6. To undertake the work formerly undertaken by the NFCC and the former PDF Steering Group until the new structures are implemented.

Workstreams were established to undertake the next stages of the work:

- a mapping exercise based on that already begun for the Branch Review Project
- based on this data, models of best practice will be developed
- divisions: how many there will be and what they will be called
- the technology requirements will be identified
- definition of what we mean by professional membership services and to set standards and benchmarks
- governance arrangements for the new structures.

For more information and the latest updates go to www.rcn.org.uk/pdf

NEWS IN BRIEF**GERRY BOLGER updates members on issues related to in-flight work****UK e-passport price increases**

Many will be aware that the UK Passport Service (UKPS) is increasing the cost of passports from its current price of £51 (standard issue) and £66 (fastrack) to £77 and £91, respectively. This is understood to allow for the introduction of the latest generation passport to international standards as well as to institute other anti-fraud measures such as enhanced background checks on applicants and preparations for face-to-face interviews for first-time adult passport applicants. The date of change is 5 October 2006, so if your passport is due for renewal, apply prior to this date and you could save £15.

Medicines management update

In May 2006, the rules around prescribing of medicine by non-medical prescribers (i.e. registered nurses and pharmacists) changed, and widened the scope of medicines to most of the British National Formulary (BNF), with some exceptions around controlled drugs.

In light of this, the guidance previously issued by the IFNA has been updated and is available on the RCN IFNA website at www.rcn-ifna.org.uk under the 'clinical practice' section.

We also are aware that several assistance companies are actively following this guidance, which improves the way nurses can administer medicines to patients whilst working, and more updates will be made available on the RCN IFNA website.

Competency update

The work to complete the competencies for in-flight nurses is now completed, with approval in principle from the RCN accreditation unit. This completes three years of work, but has ensured that the competencies are aligned to the Knowledge and Skills Framework and to Skills for Health competencies. The IFNA is in the process of having the competencies published in hard copy and online.

Website update

The RCN IFNA website, www.rcn-ifna.org.uk, is the official portal of the IFNA and contains constant updates. This includes documents of interest to in-flight nurses, as well as links to key documents, such as the Green Book, which is also outlined in this edition.

To facilitate networking, we now have a discussion board where you can ask questions, talk to other like-minded RCN IFNA members and let the committee know suggestions on subjects for study days.

Letter from the Chair

Rumour has it I have vanished, but I can assure members I am very active, and support both the work of forums within the RCN, and also the RCN IFNA. I have had some clashes with the study dates due to personal commitments and recent change of role, but this is all sorted now.

That said, the work of the committee continues, with two key study days to date this year, and another being planned in November. The IFNA Steering Committee is your committee; it serves the forum

voluntarily, and works hard to meet members' needs. It works tirelessly to support you, and our success has been due to the individual and collective energies within it. I wish to publicly thank all the committee members for their help, many contributing in uncertain times where work is not guaranteed.

The committee also integrates within the RCN to promote the function of forums. The RCN has commenced a long-term piece of work known as the Professional Development Framework (PDF), which consists of seven strands of work. One of these strands, the Professional Membership

Structure Project, has reached fever pitch with forum chairs, as the role and number of forums is under discussion. Congress allowed forums to discuss, challenge and propose solutions, and one of the pivotal concerns voiced was that forums remain national. At present, the PMS Action Group, which consists of forum representatives and chairs, is working with RCN management to go through proposals. Be assured that the IFNA will aim to maintain forums as the voice of in-flight nursing whilst striving to promote the work we do, and improve the care we give to patients.

Gerry Bolger**ILS qualification update**

The majority of the assistance companies have reviewed their minimum clinical requirements in this area and have concluded that the ILS qualification is the most appropriate for general in-flight work. This is a one-day course consisting of lectures and practical stations covering the causes and prevention of cardiorespiratory arrest, the ALS algorithm and initial resuscitation and defibrillation (both manual and AED defibrillators).

More information about the course as well as a list of ILS course centres is available through the British Resuscitation Council website (www.resus.org.uk) or by contacting them at: Resus Council (UK), 5th Floor, Tavistock House North, Tavistock Square, London, WC1H 9HM, telephone: 020 7884678.

BA's new baggage policy

As from 11 October 2006, BA will be changing their checked baggage allowance. Business Class travellers will be allowed two bags to be checked in to the hold but Economy Class passengers are allowed only one. Any bags over this allowance will be subject to an excess fee – this amount will depend on the length of the flight and will vary from £30 for domestic flights and £120 for long haul.

This will, of course, have definite implications on in-flight nurses doing stretcher cases and carrying equipment that has to be checked in.

Hopefully, the assistance companies will pre-pay when making the booking (and thereby benefit from a 20 per cent discount), but we must also be aware that we may need to remind them until everyone has become used to the new rulings.

On the subject of stretchers...

Val Pitman has a few words to say!

May I say 'well done and thank you' to Europ Assistance for being (as far as I am aware) the only assistance company to recognise and acknowledge in real terms – i.e. financially – the difference in the amount of work involved with a stretcher repatriation compared to a seated one.

Apart from the obvious extra physical work of carrying all the kit in the first place and often having to wait for hours in the backs of ambulances and grim medical centres with very few, if any, facilities, the patients are often much sicker and need much more actual nursing care.

So, come on the rest of you, these stretchers are so expensive anyway, a few extra quid wouldn't make much difference, but it would make us all feel better!

... and repats

Many of you may accuse me of stating the obvious, but a recent trip to the Rhine Valley (absolutely beautiful!) reminded me of the importance of booking taxis the night before if staying in a more remote location. The area I was in was very popular with tourists but taxis were few and far between – in fact, I think there was but one and, had I not booked him the night before, I could have been really stuck if he had taken an earlier booking.

Many years ago I was somewhere in the middle of Italy and had not had the foresight to organise transport for an early start the next day. Fortunately, the extremely kind, but ancient, night porter squeezed all my stretcher kit, me and himself into his even more ancient Fiat and dropped me off at the hospital three kilometres down the road.

I certainly learned never to risk that again!

My constructive use of time at 35,000 feet

What do you do on long-haul flights and long stopovers? Well, I have an idea for you. After about two years of full-time in-flight nursing, I was becoming fed up of Harry Potter or the latest in-flight movie. I wanted to make more constructive use of this dead time that I had on my hands.

As a teenager I was good at English, particularly literature, but going into nursing I concentrated on the sciences more at 'A' level. Feeling I had missed out on English literature, I decided to do something about it.

The Open University was recommended by a friend as a great institution to study with. So at the start of 1998 I began an undergraduate course with the Open University, beginning with a module titled: 'An introduction to the humanities', a level-one 60-credit course.

To fast-track forward to 2005, I have now achieved the 360 credits to qualify for my BA degree as well as a diploma in literature. In the process I have covered such modules as 'Fifth-century Athens', 'World health and disease' and 'The nineteenth-century novel', amongst others.

The study year was from February to October each year, with a recommended amount of study of about fourteen hours per week. Usually there are seven

assignments to hand in each year and an exam in October, which has to be passed to achieve your 60 credits.

This sounds a lot and I must confess, at times it was. There were challenges on the way, such as having a baby and moving house, but without this job and being able to do so much of the work on trips, I am not sure I would have succeeded.

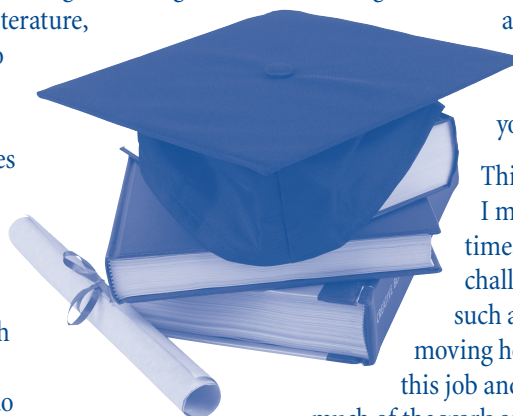
It is really a great job that we are able to do this whilst 'at work'. I think now that I have finished I will take a couple of years off to read some trashy novels and then maybe even think about doing my masters. It would be two more years of study, that is, if I do two 60-credit courses.

It has been hard work at times, needing self-discipline, but it was ultimately very rewarding – I even met new friends of all ages and backgrounds at the tutorial groups.

I thoroughly recommend it to those of you who might have the inclination to broaden and challenge your minds.

Happy flying.

Mark Jarratt, RGN, BA, Dip Lit



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