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The Highs of Flight Nursing Robert Harris

Pat: Hi, this is Pat Iyer with Legal Nurse Podcast and today we're going to talk about the site of a very special type of nursing and that is flight nursing and helicopter emergency medical services. I have with me a nurse who has extensive experience in this area as a flight nurse and an expert in the field of patient transport. He's completed thousands of flight and ground transports in his career thus far. I have with me Robert Harris.

Robert, welcome to the show.

Robert: Well, hello, Pat. It is a great pleasure. I've been excited for this for quite a while.

Pat: I think of you, Robert, when I sit in Johns Hopkins Medical Center. One time my husband had a cardiac cath, and we were delayed. We were kept in that pre-holding area for about eight hours, and I started timing it. It seemed like about every five minutes I could hear one of those helicopters coming in and landing on the roof of the hospital.

And I don't think that legal nurse consultants listening to this podcast, the vast majority, have firsthand experience about what it's like to work in that small space. So, I wanted to bring you in to talk with us about the environment, some of the charting challenges, and what we need to know as legal nurse consultants when we're looking at a record of a transport.

Robert: Absolutely, all the above. Great questions, Pat, and there's a variety of things. Number one, as you mentioned, it's a fairly, at the risk of sounding conceited, elite service because we bring a few special things to the table. Number one is airway abilities. We're sort of airway gurus. Quite often ground teams and other emergency management teams can’t provide certain things, advanced procedures

in the field. Among them are field surgical techniques such as IO access, and that's going to be intraosseous bone access.

Another procedure is chest tubes for relieving a massive hemothorax and pneumothorax in the trauma environment. Surgical crics, surgical airways, it's a very advanced skill. All flight crews are trained in this thoroughly. Needle decompressions are a standing order most everywhere. However, it needs to be done properly and quickly, and quite often the need to assess that needs to be boom, boom, boom.

We also have a huge critical care pharmacy. We can provide the precise drug we need for the right occasion. And we have massively huge protocols, which allow us to do everything. But if I had to pick one thing that distinguishes us, it's our airway capabilities, and that's something we must document very, very well. And we use video, so we upload the videos. That's something to look for in the chart: if the system is using airway confirmation on their video laryngoscope airways. That's a huge thing. That really assures the quality of the company that's providing the service. And important are Q15 minute vitals and maybe even Q5 vitals. Also look for a good follow-up on any medications given and what they did, what they didn't do, what you move to then.

Pat: Can you tell us if there's always a physician in the helicopter, or are you typically alone, or are you working off protocols? How does that part of it work?

Robert: Fantastic. Okay, in Japan there's a physician on the helicopters. It's a physician-based helicopter EMS. HEMS is the name of the field, Helicopter Emergency Medical Services. In Japan, there's a physician on the bird. And in the UK, there are sometimes physicians on birds. Here in the United States, we have a physician on satellite phone as a resource should we need to call. We call it medical direction, and that is always available.

And if you're ever reading a chart, and you see that there was some stuff that went kind of sideways and there's some weird questions where you're like, "Wow, there might've been a deviation here," the most important thing to look for as an LNC is would be was medical direction utilized for further guidance. That's one thing I could point out to our audience

here today. And other than that, it's typically a nurse and a nurse, an RN and an RN, or an RN and a paramedic. You won't see paramedic and paramedic solely. There must be an RN involved.

Pat: Got it. Do you ever have problems hearing the physician when you're talking on the satellite phone while you're inside the helicopter?

Robert: It's typically queued up through the satellite attached to the helicopter. So, we're listening to it on COMM. We have a full crash-resistant helmet to protect our heads, and there's audio boom set up and we're able to queue in and out to the radio signals to call and report to the hospitals or to contact our physicians on call, which are our medical direction. So, we can get them anywhere, but we have an immense set of standing orders in place so that should we be in the Grand Canyon or in Ocotillo Wells somewhere else without reception.

I operate out of the Southwest regions of the United States, so there are a lot of canyons. There are a lot of mountain ranges. Sometimes you're just not getting a call through, so you must be very autonomous, and yet at the same time I don't like to intimidate people who want to fly. I don't want to say, "Listen, you're going to have resources there to help you should you get stumped."

I think I answered the question. Did I get to it?

Pat: Yes. It sounds like you do have a lot of autonomy. Are there ever situations where you can think that a flight nurse might go beyond the scope of practice of the nurse or is there a great deal of latitude? And I'm not talking about a situation that you personally might've been in, but sometimes legal nurse consultants might be asked to look at the care delivered by a flight nurse. And what are some of the red flag issues where we should be concerned as legal nurse consultants?

Robert: Well, a couple of things off the top of my head. First, the protocol guides for what we do are 500 and 600 pages long and they're in both handwritten and digital formats. Most of us have them on our devices and other devices. We can look them up as needed like super-fast, and we're also trained extensively and quite aggressively. So, you're not getting the job unless you can walk the walk and talk the talk. But there is a first line you'll call a basic. You'll just call essentially your

dispatch and they'll get you through to your nursing supervisor on the shift if you just have a small question about protocols or maybe something here or there. And then if it escalates to where we need an actual decision process because we're stuck between A and B, it escalates to a physician direction, medical direction, and we're under the physician's license.

And once we're deputized, that's one of the fascinating things about this. We can do absolutely anything we've been trained to do. And if we go to court, we're going to be asked, "Where were you trained and when were you trained?" And we will show that with ease.

I'll give you an example. Say you deviated in any way because of an issue that developed or something crazy like, "Oh my goodness, we're delivering triplets on the side of the road at night and the mother is coding, and we don't have C-section protocols. What do we do?" I mean, that's our absolute worst-case scenario, but we're calling medical direction and we're getting the physician involved so that we're covered in court. That's our biggest card to play when we're out of options. But sometimes as good as we are, we're going to get stumped. So, it really depends. And the more mature provider will call medical direction earlier, get them involved. They're there for you.

Pat: I can think about cases that I've reviewed involving helicopter transport and it seems from my understanding that typically the person who is transported by helicopter is in severe shape.

Robert: Quite often.

Pat: I can think of one, a young man who was on a motorcycle. He'd just driven away from the shop, and they had not repaired his brakes properly. And he went around the curve, hit the brakes, the cycle didn't stop. He was thrown off into a windshield of a car, bounced off the windshield on the ground. And my role was to summarize what people observed about his condition when he was on the ground to see if he had any conscious pain and suffering.

He survived for about six hours, and part of that was on a helicopter transport. And he was very unstable, but what I remember most vividly about those records is that I could read everything. It was incredibly detailed.

There was not a nuance of his behavior that wasn't documented in detail. It helped me in preparing my report to show that he had some awareness. He was opening his eyes. He was trying to talk a little bit.

As I think about the environment that you work in, you're in a tiny space. You're surrounded by equipment. You've got to do charting. Are you doing charting contemporaneously or do you do it on the ground after you arrive or some combination of both?

Robert: Yes, and yes. First, I'm delighted that you came upon an advanced, very aggressive trauma chart that pleased you. I'm delighted to see that, and that means we're doing our jobs, training properly. It really quite depends on the length of transport and whether or not you have bloody gloves on or not, if you're putting chest tubes in and you're securing airways and going about all these medication things or blood transfusions, things that take up a lot of involvement from both crew members, a nurse/nurse or a nurse/paramedic.

I joke in the book, "You're going to be there until the late hours of the morning after you're off your shift just finishing these charts because they're so extensive." And they must be because you know these calls are getting billed out for a premium and we need to make sure that these charts are defensible and justifiable in every way.

So, if I'm able, if it happens, I chart. Not everything is blood and guts and body parts and bullet wounds. There are a lot of times when somebody needs to go from a non-cardiac center to a cardiac center across the state, or you're having a stroke and you get taken to the local emergency department and need to be taken to the regional neurovascular center. So, it's not all blood and guts. And sometimes on these, the patients are relatively stable. We do all the packaging and then we transport. And there's a lot of monitoring, and there's a lot of time for charting in the bird.

It's usually a combination of both. We get done what we can sometimes on the ride back. It just depends. Sometimes you're one after the other, and then you just sit down with your partners, and you look at your notes, and you hash it out for hours to get it all right, so it's really a combination. But in a perfect world, nobody wants to be there six hours after your

shift. So, we try to get it done in real time, but that's sometimes a challenge.

Pat: Can you give us a little bit of insight, and this is a not a medical decision, but I've been involved in several cases where people needed to be transported, but the weather was too bad. Have you ever been in situations where you felt like the pilot might've stretched what's acceptable in terms of taking off or you feared for your own safety or is it always smooth sailing?

Robert: Well, nothing is ever always smooth sailing Pat, as we all know in health care. But the number of incidents and HEMS in, especially you know in the helicopter world, it's very dangerous. Even on a good day with clear weather, there's lots of things that can go wrong. And there have been a lot of problems in the industry. I've lost a lot of friends, coworkers, and their patients over the years.

And there are very stringent rules now, whereby we typically try to isolate the pilot outside of what they need to know so that they don't make some sort of rash, emotional decision to override safety protocols. And there have been documented cases in the earlier days of EMS, HEMS, a decade or so ago. Anytime you go to a flight boot camp, they tell you all these crazy horror stories about things that have gone wrong in stories written in blood so that you learn from them.

And so, if we don't have it or if there's a medical issue, then we are down. Like say there's a hot start on starting up the helicopter on scene, but there's a child, something where we're very emotionally involved in this. And it's the only way to go, but our helicopter won't start properly. But the pilots say, "I can make it work." "No, absolutely not." They're trained to shut it down.

The new safety protocols are if it's not 100 percent safe, then we're no longer a utilizable resource because we're going to get you in deep trouble. Essentially, we're trying to avoid incidents at all costs because it makes the headlines and it's terrible. And we're trying to build up the image and not kill people. That's the whole point, Pat. So, pilots and nurses and paramedics have been going through rigorous training about decision making and there are lots and lots of safety protocols in place to ensure that we're not making dumb decisions that result in

death because that's the 100 percent opposite of what we're trying to do.

Pat: One of my son's friend's father was a state trooper who flew a helicopter, and he said that what he did when he sat in that seat was, he said to himself, "I am transporting a package." And he thought of people in the back as packages because he said, "If I got involved in looking at or thinking about what I was involved in, I wouldn't have been able to fly safely."

Robert: Absolutely, and that is wisdom. Blessings upon that pilot. And nowadays that is more of the culture, and that is more the opinion of the pilots. And we have an absolute rule in the industry, "Three to go, one to say no." And if it's not all three crew members involved in a, "Yes, we're good for this process," we can have an intelligent discussion about it.

It's not like a, "I don't like to fly. I don't want to…" "Okay, well it's perfect and beautiful out and everything's fine." "Like what are you… Like do you just have a stomachache?" "No, no, no, no." But if there's a legitimate concern and somebody is like, "I have a bad feeling about this because I feel we're violating A, B, and C, it's over. "Three to go, one to say no," and that is the absolute industry standard. And that's led to less deaths, less incidents, overall awesomeness, which is what we're going for.

We want to save lives. We don't want to die. I don't want to die. I love to keep doing this. That's the whole point. It's like skydiving, you know it's only fun if you get to do it again. So, everything is taking an upward turn with safety regulations and it's a new world we're living in.

Pat: It makes me think of the things that we've learned from the airline industry, some of those reservations that people had inside the plane but were in the past afraid to bring up or draw attention to or were overruled by somebody who had more authority. And we've brought that philosophy into health care with more or less success, to be honest, in terms of who's comfortable bucking authority. It sounds to me like it's part of that, "If you've got reservations speak up. We don't want you to be silent."

Robert: Absolutely and to be honest, that fantastic Tom Hanks film where they go over the life of Captain Sully, if you have not watched that, watch it, and it is bold. I hope I don't get you sued by whoever owns that film, but it's a great plug and it's so educational because it involves us. And I quite often excerpt clips from that and PowerPoint presentations and stuff. There's another book called *The Checklist Manifesto,* where the surgeon goes through all the different industries where they talk about how checklists and guidelines are literally saving lives and improving the process. It's teamwork on every level.

It used to be, "The old captain says we're good." "Well then we listen to the old captain." Nowadays it's, "You're out of your mind. I don't want to die. I'm going to speak up," and you are promoted to do that and encouraged to and held accountable if you don't. So, the entire industry is deciding to be safer and not kill people. It's wonderful. It's a wonderful move in the direction of positive improvements.

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Pat: Can you give us any insight into what typically causes helicopter crashes, those stories that you were educated on as the warning signals?

Robert: Yes. In my book there's a slightly emotional section. It's a very uplifting book, an educational book, but there's an emotional section

where I say, "I have flown with several crash survivors and I have slept in the beds of the dead."

And not to tell a bummer of an anecdote, but I once floated to a place to cover a shift. They had just lost the nurse and pilot in a crash the week before. It was engine failure at high speeds and they just went right into the side of a mountain. And the paramedic survived, although he was incredibly physically damaged but survived, and they were eventually rescued. And no names, no locations, no agencies, but this happened.

And I went to cover that base and I did my check-in in the morning, and then I went to take my nap in the nurse's room. And I closed the door to the nurse's room and on the back of the door, Pat, there was this cartoon drawing of a house, a dog, a family, you know like a scribble cartoon drawing. And across the top are the words, "Love you, daddy" and the dead nurse's child had written or drawn that the week before. And I'm going to bed in that dead nurse's bed and I wept. I mean, I just lost it because this is so real, and you're one dumb decision away from being over. I mean, you can say that anywhere in life of course, but here everything must go right. These are very sophisticated machines and sophisticated processes, and you've got to listen to everybody's input. And the second there's anything that goes wrong, you move to Plan B.

Pat: I can think about the implications having to bring down a helicopter, although, of course, you have much more maneuverability than the plane that's looking for a place to safely put down.

Robert: With a helicopter, you can land anywhere. You can land on the top of a building if you must, and quite often on hospitals we do, granted they're rated for it. But you can land in a parking lot, grass fields, riverbanks. I've done all the above in various situations with the Learjet and I've also got some experience doing international stuff. That's a different mentality because you're with the patient to the end, and you can't just land a Learjet anywhere close to a hospital. Whereas if anything goes wrong in a helicopter flight, we can divert. I realize we sort of deviated into all sorts of helicopter and medical topics here, but for the LNC crowd, if there's ever a diversion or if there's ever not a diversion, that might be something to look into in the chart.

If it had a bad outcome, was there a closer facility that could have provided resources that was overflown for whatever reason?

And there might've been a justification, maybe there's another helicopter on the pad, and they couldn't land. Maybe they were on bypass. There are all sorts of reasons where that may not be a relevant detail, but it is something to consider because we're quite blessed with a lot of resources often, and sometimes you could set a helicopter down anywhere. Yeah, so there's a lot of options in the helicopter community for where you can sit down

Even if it's in a field at night because you've had a lot of bird strikes. I've been a part of situations where they get a warning engine light and we must do an emergency landing in a field. And then we're on the radio calling the local ambulance company to come hang out with us while we wait for another helicopter. Because we're going to need more equipment, more oxygen. We have a lot of stuff, but we might be there indefinitely. So, you must wait for more resources, and you must be thinking ahead of these things. But ultimately all that comes down to the skill and knowledge of the pilot and the overall team workmanship.

I realize I'm giving long answers to these. I hope your audience is still enjoying this.

Pat: I am sure they are because they're getting some insight from a unique source. Is there a story or a situation that particularly stands out in your mind that makes you feel really good looking back on it to say, “We made a difference in this person's life?"

Robert: At the risk of sounding conceited, Pat, many, but one just warms my heart and I'll rapidly take us through it. We were launched in the desert out to this very involved situation, essentially a car tried to pass an 18-wheeler on the freeway and didn't make it. It got run over by the 18-wheeler, like something you'd see in a Fast and the Furious movie. And we encountered the patient once we landed on the closed-down freeway in the back of the ambulance. And it was a young girl, maybe 50 kg, 60 kg, and a teenager, maybe early 20s, and she had been scalped largely. And I could see that her skull was intact, but she was kind of rambling her speech and I could tell that from the mechanism

(of injury) she'd been pulled out of a sliver that remained of the front passenger seat.

She had been wedged in the door and the remainder of the seat and pulled out. And she was in C-spine precautions and my partner and I said, "Hey, her neck is clearly very, very damaged by this mechanism of injury." There are two options for intubating a patient. You can go as direct laryngoscopy, directly laryngoscopy. You could pronounce it, where you use a mechanical lifting and then you insert the tube for intubation. Or you can use a video that has a video at the tip. And so, you go in and then you go down to insert. So, there's no applied pressure on the neck. And we decided to obviously use the video approach here so we wouldn't damage her neck because we could tell those a lot of damage done anyway. The airway was placed wonderfully. We completed the call, high-fived back to the base, good job partner kind of a thing.

Three months later I get a phone call, or I get an email, from my partner saying, "Dude, check your email. Congratulations, good job." I'm like, "Oh boy, what now" you know. So, I go ahead and check my email and I'm just so apprehensive, and it was from a case manager at a rehab facility. Sometimes you get a lot of follow-up, sometimes you don't. Sometimes we're discouraged from going too aggressive, so we don't make people feel uncomfortable to get follow-up.

And so, I didn't know. I knew she had survived the initial surgeries, but that's it. That's all I knew. She wanted to meet the crews, the fire and flight crews, who had saved her life, and she had had complete C3 through C7 unstable cervical fractures. And if I would have done the cranking intubation procedure, I would have without a doubt made her a quadriplegic. But because we used our judgment and the proper equipment and technique to do the video laryngoscopy, she was walking in a halo brace with full function, expected to make a full recovery.

And they sent us a picture of her waving, walking around. I mean, once again, I wept. I weep a lot, I guess, but you don't get these happy endings every day. And that was just a beautiful moment because we made the right decision. We used the right technology and I was so blessed to be working for a company that had the right equipment. A lot of

things went together right that day to make sure that young woman's quality of life sustained. It was a good victory, Pat. Thanks for asking that, that was really sweet.

Pat: You're welcome. If somebody said to you, “Robert, I'm thinking about going into flight nursing,” what advice would you give that person?

Robert: If you're already a paramedic or an RN, then you need to be in the field for three to five years before they're going to be able to accept your application. And once again in my book, I go through a quite a laid-out process of how to make this happen for you quickly. But the first step is to become an RN. And this is an LNC podcast, I'm talking to our RNs and other members of the legal community. Become an RN. It's the way of the future.

I say in the book, "There have never been more people, and people have never been living longer." So, I hope it isn't crass, but I say in the book one of my early mentors once told me, "Health care is like the casino. Whether we like it or not, the house always wins." So, we got to be ready because they're going to be coming to us, and we got to be ready to handle these problems.

And once again, not crass, not rude, I don't mean that to be inappropriate, but it's a true statement where they're coming, and we got to be ready. And so, get the education and then build your certifications. You need to show up at that interview with the best résumé in the room. If you're asking the questions of, "Should I add this? Should I add that?” Yes, you should. If you're asking the question, you should add it. Show up, being the baddest person in the room. Show them how great you are, and they'll see it. That's the most important advice.

Pat: And I might add, I didn't introduce Robert this way, that he has the longest string of letters after his name that I think I've ever seen. Tell us what CFRN means.

Robert: Well, CFRN is my pride and joy. That's a "Certified Flight Registered Nurse. There's an organization called the BCEN, Board of Certification for Emergency Nurses, and then there are other organizations as well. But they're the primary one that coordinates with the Emergency Nurses Association and they support

certifications. And I don't know if we want a visual aid, but across the bottom down here there's a list of things. I believe it reads CFRN, CTRN, TCRN, CEN, CPN, CNPT, CCRN. And just really quick for your audience, that's Certified Flight Registered Nurse, Certified Transport Registered Nurse, Trauma Certified Nurse, Certified Emergency Nurse, Certified Pediatric Nurse, Certified Neonatal Pediatric Transport and then CCRN, which is the ICU certification.

And you know, I hate it when people shamelessly self-promote their product you know on podcasts. It's something I've swore I would never ethically do and if I could ever find someone you know I just would tell him that's inappropriate.

Pat: Tell us about your book, Robert.

Robert: What the book, no.

Pat: I think the listeners would like to know about it.

Robert: I'm the son of a career flight paramedic, so I'm one of those lucky people who grew up with a hero who did the same thing that I ended up doing. And I served in the military. I was a platoon foreman with the 1st Marine Division during the Iraq War, and they set up corpsman to challenge their LVN license. That was a hop, skip and a jump to my RN. And then I set a three-year goal to become a flight nurse. And I like to just say I was eligible in September. I interviewed and was hired in October, and then I started flying in November. So, there's a lot of good advice in here. A shameless plug or not. It's I'm telling you, amazon.com, and of course there's a million wonderful LNC publications from Patricia Iyer. And I've had such a blast talking about this and you're so generous to you know let me do that shameless plug. Thank you so much.

Pat: And for the people who are listening to this, but not watching the video, the name of your book is?

Robert: Oh, my goodness of course. How insensitive of me, *The Flight Nurse Bible: A Field Guide to Awesomeness*. And it is a beautiful book with a neon pink sunset and a gorgeous helicopter in the front and it even looks good on a shelf. So, like it, love it, hate it, it's a pretty book. But I hear good things, and I wouldn't have put my professional name and

credentials on the front of it if I didn't think it had something to offer. And once again, thank you for letting me shamelessly plug. You know I'm so humble. Who me? No.

Pat: And if people were interested in getting in touch with you, what would be the best way for them to do that?

Robert: Well, I'm very easy to find on LinkedIn, which is my primary platform for social media. It keeps the haters away. There's no trolls. It's all professional, all the time. It's a great environment for professionals to talk to each other and market things. Also, I'm on amazon.com, *The Flight Nurse Bible: A Field Guide to Awesomeness*, readily available in Kindle and paperback formats. And I'm doing an audio book for the year anniversary coming up, which will be included in any purchase. And it'll be a conversational reading of the book and that's it. Otherwise, you know RPHarrisRN@yahoo.com and shoot me any emails like questions or any… I'm here for you guys. You know like I'm a servant and I want to help. That's what I'm all about, Pat.

Thank you so much, again, for just being so sweet and having me on. I've been excited about this.

Pat: I appreciate it so much that you've spent your time with us today. And this is Pat Iyer and Robert P. Harris talking about flight nursing. I've gotten several takeaways from this show, one of which is that you must have a lot of courage and a tremendous set of skills in order to function in a cramped environment that is constantly moving. And you're under a lot of pressure to be able to deliver care to a critically ill patient. So, that requires a lot of training and it sounds like a big emphasis on safety issues to make sure that the pilot and the crew and the patient all get to the destination safely.

Robert: Perfectly said, Pat. Perfectly said.

Pat: Thank you for being with us today and thank you to you who's listening to this program. Be sure to download our mobile app, which is Biz.Edu. If you have not already gotten it, it's available at legalnursebusiness.com/bizedu. And that's where you can get our podcasts, our blogs, our free reports, our webinars, our videos and a

variety of other forms of education for legal nurse consultants. Be sure to come back next week, we'll have a new guest and a new topic, and look forward to having you on the show.

I coach LNCs through LNCAcademy. Want to talk to me for free? Set up a call with me, Pat Iyer, at http://LNC.tips/gethelp

Do you have lots of questions about being a legal nurse consultant? Are you wondering how to get clients, grow and manage a business, and dig into medical records? Do you feel a bit lost?

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