



Rural Critical Care Transportation Considerations

Guest: Dr. Eric Klotz; Founder/Director of EM STAT

- **General Considerations**
 - Long transport times in back of ambulance inherently risky.
 - Traffic accidents may lead to longer transport times than anticipated
- **Airway**
 - Going from controlled environment → less controlled → more controlled (Destination).
 - Better to control airway/intubate in the ED prior to transport than risk losing airway en-route
 - Very much a clinical gestalt
 - When transport/critical care team arrives, have a bedside discussion/review whether or not patient needs intubation, lines, pressors, etc
 - Appropriate sedation!!!! Fails en route- self extubation (long acting paralytic, hang propofol, no initial loading dose, etc)
 - Consider bolus sedative or pain med (versed or fentanyl ok for nurses to bolus- not propofol).
 - Nursing turning down propofol because of BP dropping/unsedated!
- **Breathing**
 - HFNC all the rage with covid but during long transports, Ambulance will run out of O2.
 - BiPAP, NRB, Intubation are only options
 - Not having therapy maxed out prior to departure
 - Covid slow gradual slide downhill
- **Circulation**
 - Vascular access: if critically ill, do not send with 22g in hand. Ensure that patient has multiple viable large bore peripherals. If not, place a CVC, esp. if multiple drips
 - Arterial Line: Septic Shock, Hypertensive emergency (ICH/Aortic pathology)- anything with titratable drips- challenging in back of ambulance machine reading cuff, cannot auscultate manual 2/2 engine noise (not to mention helicopter)
 - Vasopressors: Start sooner rather than later; send extra bag of norepinephrine/propofol with crew
- **What consultants do community hospitals have available?**
 - a. Surgeon/anesthesia coming from home
 - b. It may be faster to just transfer patient than to wait for specialists to come in, get OR ready, etc