



Is CT a High-Risk Area for Patient Transport?

Transports to CTs (computed tomography) have been identified as high-risk situations for patient mishaps.¹⁻³ CT was the destination of approximately 50% of the patients transported for treatment or diagnostic studies, according to Stevenson (2002), with the average time away from the unit ranging from 62 to 95 minutes.¹ Add to the volume of scans, the high level of patient acuity and it is not surprising that patient mishaps occur in this area.⁴

CT scans are not portable and are time consuming. The patient is in an isolated situation when being scanned, distant from the caregivers and at risk of a sudden change in condition as the following cases submitted to PA-PSRS indicate:

Patient "coded" after completion of the CT scan. Code unsuccessful; patient expired.

Patient was being taken off CT table after completion of CT of head when it was noted that patient did not appear the same as when he was brought in or while the scan was being done. Code called. ER doctor came immediately. Compressions were done. Pulse checked. Code team took over.

Patient had surgery and continued to complain of pain. CT ordered, gastrograffin consumed, test done, patient alert and oriented. On transport back to unit became unresponsive in elevator. Code blue initiated. Pulseless electrical activity noted on monitor. Patient expired.

A review was done of the reports of cardiac arrests in PA-PSRS where patients were away from the unit for CT scan, MRI, radiologic exams, or procedures supported by radiology such as arteriograms. The data from PA-PSRS are consistent with the literature; the CT scan clearly stands out as a location where emergent situations occur.

National hospital data indicates that the number of CT scans are three and a half times more frequently performed than MRI scans.⁴ The high volume of CT scans together with the time necessary to complete the scan expose the already compromised patient to

the risk of a mishap. Figure 1 represents the distribution of these reports to PA-PSRS by care area.

This finding supports the necessity for staff to be in readiness for an urgent situation, to have emergency equipment immediately available, and to maintain vigilance while monitoring the patient in the CT scanner or until returned to their unit.

In other reported cases, expert clinicians anticipate potential patient changes and maintain a state of readiness to the patients' and staffs' ultimate advantage:

Patient accompanied to CT by the critical care nurse. Crash cart brought to area. Patient's heart stopped prior to getting injected. Patient was successfully resuscitated.

Patient was post open heart surgery and valve repair. Remained in critical condition, on a ventilator and required a tracheostomy. Physician ordered a head, neck and chest CT. The patient was accompanied to CT by the critical care nurse. A crash cart was brought to the area as a precaution. Prior to injection the patient's heart stopped. The patient was resuscitated and returned to the critical care unit.

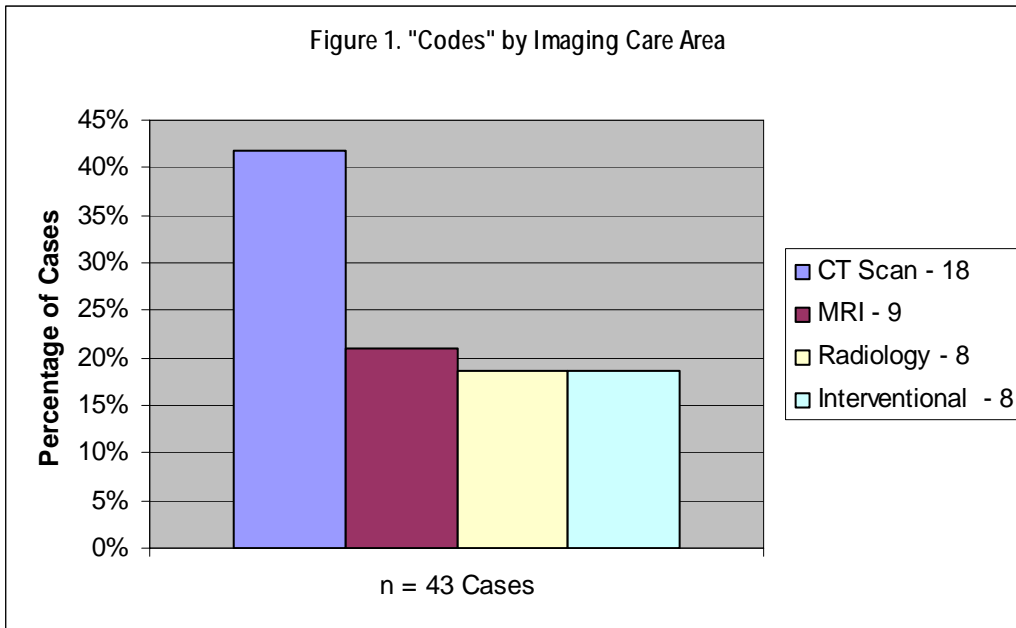
Written patient transport policies provide guidance and directives to help ensure consistently safe care for all patients requiring transportation, and they serve as a starting point for efforts to improve care. Such policies can help to eliminate any guesswork associated with orchestrating a move involving oxygen equipment and multiple personnel.⁵⁻⁷

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Is CT a High Risk Area for Patient Transport? (Continued)



Notes

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