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Respiratory Care Manager

• Accreditation • Billing • Coding • Documentation • Quality of care

—INSIDE—

Asthma interventions

Read how a new federal study examines the cost effectiveness of home interventions for asthmatics. See p. 6.

HICPAC

It's not a condition that occurs after a heavy meal—it's an infection control standard for flu season. Read p. 8.

In the news

New asthma classifications, patients heal faster when given oxygen during surgery, and more. Check out p. 10.

The JCAHO mulls safety standards

See what's under consideration for the 2007 National Patient Safety Goals on p. 12.

Did you know?

How many respiratory departments heat and humidify their low flow oxygen delivered via nasal cannula to neonates and infants? If you'd read the "RCM Talk" e-mail list in early November, you would have seen a lively discussion on the topic. Get on board today by sending an e-mail to manager-rcm_talk@hcpro.com to sign up for this FREE benefit for RCM subscribers.

RTs on rapid response teams help cut patient death rates

If your hospital hasn't already accepted rapid response teams as a reality, now's the time to do so.

Not only has the Institute for Healthcare Improvement (IHI) used the teams in its massive "100,000 Lives" nationwide campaign, but the JCAHO is considering making the in-house, on-call emergency staff a 2007 National Patient Safety Goal (see p. 12). The best part of this is that most models include an RT on each response team, making it not only a quality-improvement tool you can champion to administration, but a way to better use your department's resources.

How the teams work

The teams, which can include a

nurse, physician, and RT, work on low-priority or unscheduled tasks that can be interrupted during a shift, on-call to patient bedsides, or wherever emergencies might break out.

When a call comes in that a patient is having problems or someone observing a patient is uncomfortable with the patient's status, a rapid response team is dispatched to assess, stabilize, and even transport the patient if necessary.

The goal of the team is to reduce hospital mortality. Facilities measure a rapid response team's success by how much it reduces the number of deaths and code blues (cardiac arrest) per 1,000

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Training and communication are critical keys for disaster planning

Editor's note: Hurricane Katrina's devastation inspired several hospitals to revisit their disaster plans—and it might be time for you to give your respiratory department a check-up as well.

Making rounds at Charity Hospital in New Orleans required resilience after Hurricane Katrina battered the Gulf Coast.

"The water was just pouring in,"

Ruth Berggren, MD, told television news network CNN on August 31. "We were dodging water, ceiling tiles."

Soon after one of the deadliest hurricanes in American history made landfall southeast of New Orleans on August 29, some of the levees protecting the city from Lake Pontchartrain and the Mississippi River failed, allowing water to flood the city. The hurricane

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Rapid response

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patient discharges.

“We’re everywhere in the hospital—we’re in every intensive care unit [ICU], we respond to emergencies, we respond to code blues, we respond to trauma team calls,” says **Homer Rodriguez, RRT**, director of respiratory therapy at the University of Kansas (KU) Hospital, which began its rapid response program in December 2004.

“So we’re already first responders and we’re trained as part of our professional training to respond to airway emergencies.”

KU Hospital’s story

The statistics speak for the success of the teams at KU Hospital: Before the rapid response team, fewer than 20% of code blue patients survived. Now, more than 66% do. As of early September, the overall patient mortality rate had fallen from 2.3% to 2%, and the hospital’s goal in joining the IHI’s 100,000 Lives campaign (of which rapid response teams are one of the elements) is to knock it down to 1.75%.

An RT and intensive care nurse respond to every call received by the teams within minutes. Sometimes they come with a physician in tow, depending on the department and the patient’s condition. Anyone can call in a team—nurses on the floor, visitors, physicians, patients’ families, or cleaning staff.

Although anyone can call a KU Hospital rapid response team because of unease with a patient’s condition, other events trigger a call, too. These triggers include

- a rise or drop in respiratory rates
- declining neural or mental status (e.g., a patient becoming unresponsive or hyper-responsive)
- changing blood gas stats
- respiratory failure
- a spike or drop in heart rate or blood pressure

“Our goal is to respond within five minutes,” says

David Northrop, BSRT, RRT, one of the responders at KU Hospital, who says that teams on average get one or two calls per day at the 485-bed facility, which covers 14,000 patients and 350,000 patient visits annually. “Most of the time, we’re there within one to two minutes.”

“Our goal is to respond within five minutes. Most of the time, we’re there within one to two minutes.”

—David Northrop, BSRT, RRT

The conditions the responders address can run the gamut from simple glucose treatments for diabetic emergencies to airway problems that land patients in the ICU, says **Dan Conyers, MS, RRT**, another therapist active on the team.

A key goal for the hospital’s team is staving off sepsis, a severe condition that often entails a prolonged hospital stay and for which survival rates are low.

The team is ready for anything. The idea is to mobilize what Northrop calls “an ICU-like environment” around a crashing or critical-care patient within minutes, so the team can prevent his or her condition from deteriorating.

The team stays around until the patient’s physician arrives and takes over and decides that the situation is under control and can be handled without the nurse and RT.

Tips for starting your own team

KU Hospital is spreading the word on the rapid response team and is helping other Kansas hospitals start their own. The RTs **RCM** interviewed offered several pieces of advice for other managers who might consider starting their own rapid response team:

- Contact IHI. This organization offers a wealth of information on its Web site, and can also dispatch a team to help your hospital get a rapid response team up and running.
- Welcome false alarms. Be patient—especially during the launch phase of a rapid-response program. Use false alarms to educate patients and staff on how to best use this resource.
- Pick RTs and nurses with specialty training or cre-

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dentials in emergency services who have demonstrated poise under stressful circumstances.

- Have carts or boxes with point-of-care emergency respiratory and lab testing equipment for the teams on each floor.
- You can't have enough education and training for

the rapid response team members.

Above all, when investigating your department's ability to launch a rapid response team program, remember that it's a concept that you can customize to fit the needs and patient population of your facility. ■

IHI's '100,000 Lives' campaign

The Institute for Healthcare Improvement (IHI) leads one of the nation's most organized initiatives for building rapid response teams.

Yet deploying more rapid response teams is just one aspect of the IHI's "100,000 Lives" campaign.

The concept behind the campaign is to improve quality measures in time to lower hospital mortality rates by 100,000 people by June 14, 2006. The organization is serious about measuring its progress toward the goal, too: More than 2,800 hospitals signed up for the campaign at IHI's Web site (www.ibi.org/IHI/Programs/Campaign) as of late October.

To be a part of the campaign, member hospitals must submit mortality data for IHI to track. Hospitals in each of the 50 states and the District of Columbia have joined the campaign thus far.

Other steps in the 100,000 Lives campaign include the following proven interventions to save lives:

- Administering evidence-based care for heart attack patients. Consistently delivering key measures such as early administration of aspirin and beta blockers prevents patient deaths.
- Preventing adverse drug events by using medication reconciliation, a system requiring a list of all of a patient's medications—even for unrelated illnesses—should be compiled and reconciled to ensure that the patient receives the right medications at the correct dosages at admission, discharge, and before transferring a patient to another care unit.

- Preventing central line infections by consistently delivering the five steps the IHI calls the "central line bundle."

- Preventing surgical site infections by reliably delivering the correct perioperative care, maintaining glucose levels, and avoiding shaving hair at the surgical site.

- Preventing ventilator-associated pneumonia—a quality-improvement step many respiratory care managers have taken on independently—by following five steps collectively called the "ventilator bundle." These steps include elevating the head of the hospital bed to between 30 degrees and 45 degrees, a step proven to reduce mortality and length of stay in intensive care units.

"The 100,000 Lives campaign has captured the good will and intentions of American hospitals at a rate and in sheer numbers we could never have predicted," said Donald Berwick, MD, MPP, president and CEO of IHI, in an August press release.

"When over 2,500 hospitals decide to improve at the same time, it really is possible to see how proven, life-saving medical practices can become the norm in hospital care," he said. We're now starting to hear about early successes with the . . . interventions, and we look forward to sharing the progress of this initiative in the weeks and months ahead. It's also never too late to enroll."

IHI offers a free guide at www.ibi.org/NR/rdonlyres/9134B60C-BB05-4735-8DF4-D96D09CC9EAB/0/RRTHowtoGuideFINAL71505.pdf to help hospitals set up rapid response teams of their own. ■

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Hurricane Katrina

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and ensuing flood waters cut power lines and contaminated drinking water.

The lack of power and clean drinking water and the resulting evacuation of a major American city may cause hospitals to revisit their disaster plans in the coming months, and accreditors and regulators may place added emphasis on preparedness to avoid future chaos.

In the wake of the September 11, 2001, terrorist attacks, many respiratory department managers devised new department-level disaster plans and helped their hospitals remake their facilitywide contingencies. Although September 11 turned managers' attentions toward man-made disasters, Katrina showed how natural disasters can bring a different set of problems for healthcare workers to face.

Standards played out

The JCAHO has numerous standards governing emergency preparedness, including the following:

- **EC.2.10**—The hospital identifies security risks
- **EC.4.10**—The hospital addresses emergency management
- **EC.4.20**—The hospital conducts emergency drills
- **EC.7.20**—The hospital provides an emergency electrical source

Standard LD.3.15, which governs patient flow, also applies to emergency situations, said **Darlene Christiansen, RN, LNHA, MBA**, director of the Standards Interpretation Group and Office of Quality Monitoring at the JCAHO, during the JCAHO Hospital Executive Briefings conference in Rosemont, IL, on September 1. Hospitals need to be able to provide care for triaged patients and those waiting for hospital beds.

But standards became an afterthought soon after Hurricane Katrina moved out of New Orleans' French Quarter. Once the power went out, many hospitals operated on backup generators. But when Governor Kathleen Blanco ordered an evacuation of the city on August 30, officials had to scramble to move patients and treat those in need of dialysis and other

life-saving procedures that require water and electricity. Evacuations of some hospitals took days to complete, according to media reports.

"We didn't expect what happened in New Orleans," said Christiansen. "We will work with [hospitals] to help them improve their situation."

The JCAHO Standards Interpretation Group will discuss environment of care issues with organizations in the wake of Katrina, commission spokesperson **Mark Forstneger** says. You can reach that office by calling 630/792-5900.

The commission suspended survey activity in the affected areas, including New Orleans and Biloxi, MS, Forstneger says. "The impact of Hurricane Katrina will last longer than a few weeks, and the Joint Commission is prepared to accommodate that reality for organizations in affected areas."

Start planning in advance

Organizations will need to collaborate with neighboring healthcare facilities when planning for a disaster, Christiansen said. One potential situation would be moving long-term patients to a long-term care facility so acute-care hospitals can focus on first aid, she said.

If a major hurricane or other disaster gives hospitals time to prepare, organizations should discharge every patient who is able to go home to free up bed space, says **David Teeter, PharmD**, an emergency management consultant and pharmacist at Wishard Hospital in Indianapolis.

Hospitals should also stop elective procedures and identify patients who receive home care and may need critical medications such as chemotherapy, he says.

Organizations should utilize their drug-procurement database to identify critical medications they may need for their intensive care units (ICU) and determine whether they will use backup generators or ice to keep cool any medications that need refrigeration, Teeter says.

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Also consider temperature controls and alternative storage space for shelf stock. If the air conditioning fails, medications that must be kept at room temperature will bake in the heat and humidity, Teeter says.

Every facility is vulnerable

Facilities such as rehabilitation hospitals should not assume they can divert patients to an acute-care hospital during a disaster such as a hurricane or a terrorist attack, Christiansen said. Patients will go there simply because the facility is a hospital.

If you were to experience a catastrophe such as the September 11 terrorist attacks, the rehabilitation hospital CEO “would tell you he [or she] saw masses of people walking to the hospital,” said Christiansen. “How would you handle that in your geographic area?”

But Teeter cautions that all disasters start locally, and relief aid from state and federal agencies takes time to arrive, which places an added emphasis on local hospital preparedness. “They could be on their own or receive little help for hours or days,” he says about local hospitals. “Federal and state assets can be positioned in disasters with warning periods such as this. But it still takes time to get to the affected areas and deliver services.” For example, obtaining medications from the federal government could take several days.

Innovation may save lives

The last medical procedure completed at Charity Hospital was on the morning of August 30, when Berggren performed a lumbar puncture on a patient, she told CNN. The hospital’s ICU was operating on diesel-powered generators and performing basic first aid only, she said.

Berggren was concerned most about patients in need of dialysis treatments, who had to be evacuated to another facility outside of the city.

Some medical equipment may be able to operate on backup generators or batteries, Teeter says. But in some situations, manually pumping airbags for patients on ventilators or other primitive treatments may be necessary until evacuations can take place, he says. “People always come up with new ways of doing things.”

Resources might not be there

A lack of communication and security hampered evacuation efforts, an ambulance official told CNN on August 31. A massive evacuation effort to move refugees from the Louisiana Superdome in New Orleans to the Astrodome in Houston was suspended temporarily on September 1 when shots were fired at a military helicopter.

Regulators such as the JCAHO may want hospitals to develop more in-depth drill scenarios after observing the extreme challenges hospitals faced in New Orleans and the Gulf Region, says **Mark Cavanaugh, CFPS**, fire marshal at University of Rochester (NY) Strong Memorial Hospital. JCAHO officials may require drills that put stress on a hospital system’s resources, which the conditions in the Gulf Coast clearly did in real-life evacuations.

Forstneger, the JCAHO spokesperson, says it is too soon to tell whether the commission will revise any emergency-related standards. The commission has drafted emergency drill standards but has yet to approve them.

But along with better drills comes the need to dedicate resources for such training, possibly through a national commitment, Cavanaugh says. It’s common to hear that hospitals couldn’t convince a local fire department or ambulance company to participate in a drill, which decreases the effectiveness of the training, he says.

Practice communication strategies

Identifying a chain of command in a disaster is critical to maintaining order at a hospital during chaotic situations, Christiansen said. Hospitals also need to identify backup communication methods in case the phone lines go out.

Communication plans must be in place and practiced to ensure that they work during a disaster, Teeter says. Cell phones may not work, but satellite phones and ham radios might, he says.

Pay phones can provide another means of communication if landlines still work, he says. “Practice before something happens. Usually the first or second thing talked about [after a disaster] is communication.” ■

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Cut costs with home interventions for asthmatics

In releasing their latest asthma study, National Institutes of Health researchers in October gave respiratory department managers a useful data tool for helping patients.

The study also might help cut emergency room (ER) visits through its detailed cost analysis of how home asthma interventions cut symptoms and ER visits.

Home interventions, when targeted at a moderate to severe asthmatic's particular allergens and when conducted by two healthcare educators, gave children an average of 38 more symptom-free days over a two-year span than the control group children.

The average cost was \$27.57 per symptom-free day, as opposed to a potential ER visit on a non-symptom-free day at \$390 per visit (see the chart below).

"The findings of this study will enable policymakers and healthcare providers to more effectively allocate resources to achieve maximum benefits," said author Peter Gergen, MD, MPH, of the National Institute of Allergy and Infectious Diseases' Division of Allergy, Immunology, and Transplantation in a press release.

A rundown of asthma costs

National Institutes of Health researchers calculated the following costs for asthma treatment in their study showing how home interventions can cut such costs and improve patients' conditions:

Item	Cost
Scheduled doctor visit	\$35.89
Unscheduled clinic visit	\$49.34
Emergency department visit	\$390.00
Inpatient hospital day	\$1,131.00
Anti-inflammatory medications	\$46.00
Cromolyn inhalers	\$70.16
Beta-agonist inhalers	\$20.49

Source: Journal of Allergy & Clinical Immunology.

The National Institute of Environmental Health Sciences (NIEHS) cosponsored the study, which was part of a larger study entitled *Inner-City Asthma Study*. RCM accessed the new study on October 27 in the *Journal of Allergy and Clinical Immunology's* "in press" section. This is the second published article from the study's data; the first came out last year in the *New England Journal of Medicine*.

The study examined 900 children ages 5–11 with moderate to severe asthma. Most of the children were African-American or Hispanic, living in low-income sections of the Bronx, NY; Boston; Chicago; Dallas; Manhattan, NY; Seattle/Tacoma, WA; and Tucson, AZ.

The vicious cycle

It's a well-known trend that more people who live in inner cities have asthma. City life offers a dense mix of irritants (e.g., diesel exhaust) and allergens (e.g., cockroach shells) that are present—but less prevalent—elsewhere.

Managers of respiratory departments at inner-city hospitals also play a role in the cycle of poverty: When asthmatic children from low-income families can't afford to purchase medication, their symptoms sometimes get so out of hand that they require an ER visit to control them.

When a patient can't afford medication, chances are he or she can't afford health insurance, either, and might not be able to cover the ER bill. Respiratory department managers at hospitals where this is an economic concern can sponsor their own home intervention programs within the facility. They also can team up with external groups such as their local asthma coalition, city health departments, or a children's foundation to sponsor home interventions.

In the *Inner-City Asthma Study's* model, the healthcare providers gave test patients skin pricks to determine what they were allergic to. Then, they followed up with home visits.

If a patient was allergic to cockroach shells, the family

would be taught to cook and clean in such a way to reduce cockroach problems. When a dust allergy was involved, educators focused on bed covers and other measures to cut down on mites. Also, they might provide air-purification equipment in homes where smokers live.

"This study showed that reducing the exposures [to cockroaches, dust mites, and pet dander] was beneficial in terms of clinical improvement," says **Meyer Kattan, MD, CM**, study author and pediatrician at New York's Mount Sinai School of Medicine, adding that the key was customizing the measures taken to the particular patient's allergies.

Proving the case

How do you use the cost-computing data from the study? First, determine to whom you're selling the intervention program. Then, tailor your presentation to their priorities.

"What's the value of the intervention?" Kattan asks. "The value may differ depending on who you are. A third-party payer may think, 'All we're interested in [are] hospitalizations and emergency room visits . . . not . . . whether they have more or less symptoms.' For an employer, they might not want the parents to miss work, so they don't want the kids absent from school. This study gives the costs for [each] particular outcome."

Kattan adds that managers interested in cutting costs from the home intervention model his study used can

dispatch one healthcare provider to a patient's home instead of two. He sees RTs as a potentially good fit for the job, especially those with the asthma educator credentials.

However you use the results, there's no debating that home interventions work. "These results show that tailored interventions such as these may have a substantial long-term effect on asthma symptoms and resource use among inner-city children," NIEHS Director David A. Schwartz, MD, said in a press release announcing the study results.

"They may be particularly beneficial for asthmatic children who are exposed to multiple allergens and lack the proper access to quality healthcare," he said. ■

Illustration by
Dave Harbaugh



"I can't have dinner at your place Greg. Remember, I'm an RT. You have dust mites, pet dander, and a computer virus..."

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Guidelines help defend RTs against SARS, bird flu

Respiratory managers find themselves caught in the middle between scientists and politicians when it comes to the Center for Disease Control's new Healthcare Infection Control Practices Advisory Committee (HICPAC) disinfection and sterilization guidelines.

The guidelines remain shelved due to a tug of war between scientists and politicians who cannot agree upon the specific recommendations.

When released, the guidelines, which HICPAC cleared in February 2003, will be the first such guidance for RTs since the publication of the Association for Professionals in Infection Control and Epidemiology's (APIC) *Guidelines for Selection and Use of Disinfectants* in 1996.

Since then, the IC world has clamored for more timely information and updated recommendations, says **Robert Sharbaugh, PhD**, a consultant with 27 years of experience in clinical epidemiology, microbiology, and infection control (IC).

William Rutala, MPH, discussed the proposed new HICPAC guidelines at length during APIC's 32nd Annual Educational Conference and International Meeting in June in Baltimore and indicated that the guidelines will provide insight into several areas of interest to respiratory care practitioners, who worry about the next big flu epidemic or treating new diseases such as SARS. RTs do not want to be the conduit for their spread via person-to-person contact or through ventilatory and blood-gas diagnostic equipment.

Sharbaugh viewed the proposed guidelines and offered his opinion about what changes healthcare providers can expect.

Emerging pathogens

The emergence of SARS, avian influenza, and noroviruses has called into question the efficacy against these organisms of disinfectants. But recent studies have shown that standard disinfection and sterilization procedures are adequate when working with patient-care devices thought or known to be contaminated with these pathogens.

Also, recent controversy regarding the dangers surrounding unclean endoscopes and endocavitary probes (e.g., transesophageal echocardiography, vaginal, and rectal probes) makes this a timely subject.

Levels of disinfection

The healthcare industry has long recognized three levels of disinfection—high, intermediate, and low—to address the use of a specific item.

"Some degree of confusion among infection control professionals, especially those with limited experience, has persisted to this day [regarding] the need for intermediate-level disinfection versus high-level disinfection," Sharbaugh says.

The new guidelines may recommend a discontinuation of all intermediate-level disinfection, which means that all semicritical items (i.e., those that come in contact with either mucous membranes or nonintact skin) would require high-level disinfection.

Critical items (i.e., those that enter the bloodstream or other sterile areas of the body) will continue to require sterilization, while noncritical items will require only low-level disinfection.

Another important change is the expected recommendation that low-level disinfection can be achieved within 30–60 seconds, as opposed to the 10-minute duration long held to be the accepted practice, says Sharbaugh.

In recent years, the Federal Drug Administration has approved several liquid sterilization products. Find a complete list of these products online at www.epa.gov/oppad001/chemregindex.htm.

Biological monitors

Sharbaugh anticipated several changes regarding the use of biological monitors in various sterilization procedures. They include the following:

- Steam (*Geobacillus stearothermophilus*)
- Ethylene oxide (*B. atrophaeus*)
- Plasma sterilization (*G. stearothermophilus*)
- Peracetic acid (*G. stearothermophilus*) ■

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Sample endoscope reprocessing competency evaluation

Competency criteria:

Circle appropriate

outcome measure:

Competencies

Met	Not met	NA	Verbalizes knowledge of cleaning and disinfecting solutions used, labeling, length of effective use life and soak times.
Met	Not met	NA	Documents concentration of glutaraldehyde appropriately (e.g., if used daily, test daily).
Met	Not met	NA	Wears personal protective equipment, including gown, gloves, eyewear.
Met	Not met	NA	Demonstrates initial gross decontamination of exterior of scope and accessories. Wipes exterior of scope with clean cloth soaked in detergent or enzymatic cleaner.
Met	Not met	NA	Leak-tests scope.
Met	Not met	NA	Uses suction to fill channels with detergent or enzymatic cleaner.
Met	Not met	NA	Demonstrates the process of manual washing and brushing all channels, ports, and valves with appropriately prepared detergent or enzymatic cleaner.
Met	Not met	NA	Brushes lip of biopsy port.
Met	Not met	NA	Rinses exterior of scope, uses suction to rinse interior until fluid is clear, ends by suctioning air to clear fluid from scope.
Met	Not met	NA	Fills interior channels with glutaraldehyde and immerses completely to prevent air bubbles. Uses 20-minute immersion time.
Met	Not met	NA	Demonstrates the proper use of the automatic processor. Verbalizes knowledge of test cycles before and after use. Uses biological and chemical indicators.
Met	Not met	NA	Avoids contaminating clean and disinfected items with dirty gloves. Washes hands after removing dirty gloves. Dons clean gloves prior to removing scope/accessories from glutaraldehyde.
Met	Not met	NA	Rinses scope with either sterile water, filtered water, or tap water. Uses clean suction.
Met	Not met	NA	Uses forced air to dry the scope followed by alcohol to assist in drying. Then purges scope with forced air.
Met	Not met	NA	Demonstrates proper cleaning, high-level disinfection, rinsing, and drying of all accessories.
Met	Not met	NA	Demonstrates proper cleaning and sterilization of biopsy forceps and other cutting instruments which enter sterile body sites.
Met	Not met	NA	Labels or packages disinfected scopes/accessories to indicate disinfection has been done.
Met	Not met	NA	Is able to state conditions indicating a scope has not been disinfected (e.g., if not labeled or packaged, scope is considered contaminated and requires high-level disinfection prior to use).
Met	Not met	NA	Properly stores scope/accessories in a clean location.
Met	Not met	NA	Empties and disinfects water bottles.
Met	Not met	NA	Disinfects brushes.
Met	Not met	NA	Empties and cleans pans.
Met	Not met	NA	Removes personal protective gear and discards appropriately.
Met	Not met	NA	Washes hands before leaving reprocessing room.

I certify that this individual has met all competencies for reprocessing endoscopes.

Signature: _____ Date: _____

Print name: _____ Title: _____

Source: University of North Carolina Healthcare System. Go to www.unc.edu/depts/spice/drs/Endoscope-Competency.doc to view the form online.

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In the news

► Old lung cancer therapies turn out to be a new idea when combined for better outcomes

Lung cancer patients whose tumors doctors consider inoperable might benefit from minimally invasive surgery combined with brachytherapy.

The combination procedure implants tiny radioactive seeds at the margins of the tumor, according to researchers at Montefiore Medical Center, who presented their findings October 17 during the American Society of Therapeutic Radiation and Oncology meeting in Denver.

The findings open up a new treatment option for many lung cancer patients who previously had little hope of survival.

“Although brachytherapy is not new, this is the first study to demonstrate that combining modern minimally invasive and precision radiation techniques yields significantly improved results,” said Subhakar Mutyala, MD, director of brachytherapy in the Department of Radiation Oncology at Montefiore and the lead author of the study.

“The study suggests two things,” he said. “First, brachytherapy has a ‘low toxicity’ and consequently is safe for these patients. Second, by combining surgery and brachytherapy, many patients with previously inoperable tumors now can be operated on.”

► Mayo Clinic doctor throws mild, moderate, and severe asthma classifications out the door

Forget the 15-year-old standards of classifying asthma patients according to mild, moderate, or severe cases, said Mayo Clinic allergist James Li, MD, PhD, and his colleagues in the November *Journal of Allergy and Clinical Immunology*.

Instead, he advocates classifying asthma patients according to their symptom occurrence and control. Why? He hypothesizes that working toward total control of symptoms instead of designing treatment cases according to severity will help healthcare providers improve asthmatics’ quality of life.

“People with asthma can expect to control the asthma, not to have the asthma control them,” said Li, lead author of the paper. “It’s all about asthmatics’ quality of life: waking up in the middle of the night wheezing, constantly using rescue medications, having to excuse themselves from sports teams or needing to leave work due to an attack—that’s no life.”

► Vaccinate children to stop pneumonia in adults

Since being approved for use in children in March 2000 by the Food and Drug Administration, the pneumococcal conjugate (PCV-7) pneumonia vaccine prevented 12,500 cases of pneumonia and 1,100 deaths among adults older than 50.

The reason is simple: Older adults—who are vulnerable to the disease—are around fewer sick children, and therefore contract pneumonia less often, according to the October 26 *Journal of the American Medical Association*.

“In the U.S. population, use of PCV-7 for children has been an effective means of preventing disease in older adults,” the CDC-funded authors conclude. “Policy makers elsewhere who are considering whether to incorporate PCV-7 into their routine infant immunization programs and who are weighing its cost-effectiveness should consider the benefits seen in older adults.”

► New procedure circumvents airway problems

Intubation failures can result in emergency tracheotomies in high-risk cases, but a new procedure can help cut down on their occurrence, according to the July *Canadian Journal of Anesthesia*.

No significant complications were reported in an 88-patient study of head-and-neck cancer patients led by University of Alabama-Birmingham anesthesiologist James Boyce, MD. Boyce helped develop this technique as a simple alternative for delivering oxygen prior to establishment of a more permanent airway.

“Intubation failures can result in emergency tracheotomies in high-risk cases, but a preventive punc-

ture through the cricoid membrane of the throat eliminates that crisis possibility,” Boyce says. “[One example is when] cancer of the tongue partially obstructs the airway and the patient is at risk of complete closure during intubation. We gain a superior margin of safety by initially establishing a viable airway below the obstruction.”

► **Generic prescriptions could save \$20 billion**

RTs know the familiar cycle, especially when dealing with asthmatics in emergency rooms (ER): Some people can’t afford the name-brand medication their doctors prescribe, so they end up getting even more expensive treatment in the ER.

This treatment costs the hospital more money, and the patients still can’t afford their meds, so they come back as “repeat customers.” In some cases, that cycle could be broken with the use of generic drugs—including the popular asthma drug Advair, slated to go generic in 2008.

In the United States, doctors prescribe generics only half of the time that they can—and if they bump that up to 75% nationwide, it could save \$20 billion per year, according to a study published online by Express Scripts, a pharmacy benefit management company that services insurance companies and managed-care organizations covering 55 million patients in the United States and Canada.

Filling a generic drug prescription costs approximately \$60 less than filling one for a brand name drug. Consumers also pay a lower copayment for generic medications, saving \$10 or more per prescription on average compared to branded medications.

Massachusetts, Oregon, and New Mexico had the highest generic fill rates, at 56% each.

The lowest generic fill rates were in New Jersey (41%) and New York (43%). Southern states, including Texas, Louisiana, and Florida, opted for generics for fewer than 46% of all prescriptions filled in 2004.

View the report at www.express-scripts.com/ourcompany/news/outcomesresearch/onlinepublications/.

► **Patients heal faster when given oxygen**

Attention RTs in charge of purchasing supplies for and administering oxygen therapy: There might be a bump in demand coming.

Patients recover faster and avoid nasty complications such as surgical site infections when they’re given oxygen during surgery, according to the October 26 *Journal of the American Medical Association*.

F. Javier Belda, MD, PhD, of the Hospital Clínico Universitario de Valencia, Spain, and colleagues conducted a double-blind, randomized controlled trial including 300 patients aged 18–80 years who underwent elective colorectal surgery in 14 Spanish hospitals from March 1, 2003, to October 31, 2004. “We found that 80% supplemental oxygen reduced the risk of surgical site infection by 39%,” the researchers wrote. “Patients with infections had significantly longer hospital stays and delays to ambulation. Supplemental oxygen appears to confer few risks to the patient, has little associated cost, and should be considered part of ongoing quality improvement activities related to surgical care.”

► **Bird flu on the way, but awareness can help**

It’s time for the annual reminder for you and your staff to stick to basic hygiene infection control precautions such as frequent hand washing and covering the mouth when coughing, both of which can help prevent the spread of viruses including colds, the common flu, or the more deadly avian flu.

The stakes are higher this year, said James D. McGlothlin, an associate professor in the Purdue School of Health Sciences. A 22-year Centers for Disease Control and Prevention veteran now in the private sector, McGlothlin issued a statement urging healthcare practitioners to take hygiene seriously this year. The spread of avian flu—carried by migratory birds from Asia to the Middle East and Europe—bears resemblance to a 1918 influenza that killed 50 million people worldwide.

“Those measures are especially important because, while a vaccine has been developed, there is not nearly enough to go around and won’t be at least for another year,” McGlothlin said. ■

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The JCAHO names potential 2007 national goals

Bar coding to identify patients and creating rapid response teams are among the potential 2007 National Patient Safety Goals the JCAHO considered during a mid-September meeting.

Respiratory managers who sit on safety committees and are proactive in promoting patient safety initiatives in their departments should take note of these proposed goals.

The JCAHO also planned to examine draft leadership standards that regulate hospitals' assessment of a safety culture.

"This is a big topic that we might put one or two requirements in the goals," **Richard Croteau, MD**, JCAHO executive director for strategic initiatives, said during the Hospital Executive Briefings conference in Rosemont, IL, on September 1. "And we might put more in the standards."

If the commission approves the standards for field review, which Croteau said he hopes will happen, the

draft should be posted to the JCAHO Web site (www.jcabo.org).

Among the topics the Sentinel Event Advisory Group considered when it met September 12 were

- assessing a culture of safety
- reducing worker fatigue
- using technology such as bar coding to help identify patients
- patient elopement
- improving safety of anticoagulants, insulin, and narcotics
- rapid response teams

Putting forth the proposal helps draw more attention to the issue of patient safety, Croteau said. "This is a risky business. A culture of safety is a culture [in which] risk is acknowledged and we work to reduce harm." Hospitals can start to involve patients in their care now, he said. A benchmark is the Dana-Farber Cancer Institute in Boston, which has former patients sit on numerous committees to provide a different perspective on certain issues, he said. ■

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• Phone: 781/639-1872, Ext. 3203
• Mail: 200 Hoods Lane, Marblehead, MA 01945
• E-mail: cconnors@hcpro.com
• Fax: 781/639-2982
Editor, Don Fluckinger
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