



Adult Acute Care

September / October 2002

Bulletin

Notes from the Editor

by Jeff Whitnack, RRT, RPFT

In the last issue of the Bulletin, Keith Lamb brought us a case study in which a patient's ventilatory and oxygenation status, via TGI and NO administration, respectively, were optimized. However, despite the spectacular improvement in gas exchange, the patient's declining status made support withdrawal the only reasonable course.

On the one hand, I strongly feel RTs need to be involved in issues regarding end-of-life care. Sometimes, I feel that we continue with futile efforts until what is being practiced resembles more a form of magic than one of medicine; the term "Shaman" might better apply than "Doctor" when all we are doing is creating an illusion.

But on the other hand, our expertise in critical care - the very thing that enables us to assist in saving so many - has a legitimate "by-product." That "by-product" is that many will die with good ABGs.

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Reflections on Professionalism: Practice Makes Perfect

by Jeff Whitnack, RRT, RPFT

Once, while watching my son at one of his Kung Fu classes, I heard the instructor say that the physical moves being practiced aren't natural and therefore must be repeated over and over until they become second nature.

In some ways I think this applies to professionalism as well. I'm not talking about the basics, such as patient confidentiality or the injunction to not commit outright illegal or unethical acts, the most basic professional trust placed in us by our patients. I'm talking about overcoming the subtle, daily pressure that can slowly chip away at our professional mindset or identity.

At far too many hospitals the respiratory therapist still lacks the professional recognition afforded others of similar responsibility. At far too many hospitals the respiratory therapist is handed a very heavy treatment load and then judged more on a productivity scale befitting a factory worker than on his or her clinical effectiveness. And at far too many hospitals many respiratory therapists have let the profession become just a job. This, of course, can become a vicious cycle, leading back to the first sentence in this paragraph.

Looking over the AARC's Guide to Professionalism (go to www.aarc.org, then click on the Resources link on the left bar to find it) it occurred to me that, for many, the tendency to neglect professionalism is rather insidious. To work under the pressures and conditions that many of us do and still maintain our professional quest and identity requires that we sometimes go counter to the natural tendency to follow the path of least resistance - in other words, professionalism doesn't always come naturally, and we must consciously practice it to make it second nature. Everyday I take stock of what I've done well and, well, what I should have done differently. Everyday on the way home I reflect back on the victories, the defeats and what was both inspiring and demoralizing.

A profession like ours has professional standards and conduct because the public has placed both its trust in us and is vulnerable to harm due to any lapses on our part. As respiratory therapists, we serve in a very important and critical niche in our health care system. If we are to fulfill our appointed duties we must have a professional base. We must not only practice professionalism every day on the job, we must perfect it. ♦

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SECTION LISTSERVE:

Start networking with your colleagues via the section listserv. Go to the section home page on www.aarc.org and follow the directions to sign up.

Adult Acute Care Specialty Practitioner of the Year: Keith Lamb, RRT

by Nick Widder, RRT

It is my great pleasure to announce our choice for Adult Acute Care Specialty Practitioner of the Year: Keith Lamb, RRT.

Keith is a relative newcomer to our profession, having entered the field just a couple of years ago after first serving in the U.S. Marine Corps. But as the night lead therapist at Christiana Hospital in Newark, DE, he is quickly rising through the ranks, and he has also fully embraced his professional organization, not only by joining the AARC and the section, but also by sharing his expertise through articles in this Bulletin.

Keith was good enough to share his initial impressions of respiratory care through his contribution to the Bulletin last January, and he again contributed in May, this time giving us a

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What's Weight Got To Do With It?

A new study from Spanish investigators has found that COPD patients with low body weight exhibit more muscle atrophy and worse exercise capacity than those with a normal body mass index (BMI) - even when suffering from similar degrees of lung function impairment.

According to the researchers, who published their findings in the second August issue of the American Journal of Respiratory and Critical Care Medicine, skeletal muscle cell death and atrophy were increased in seven COPD patients with low BMI when compared to three other groups: eight normal weight COPD patients, eight healthy volunteers and six sedentary volunteers.

The researchers also discovered that exercise capacity in the underweight patients was better correlated with their BMI than with the degree of their airflow restriction. ♦

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Pay Me Now or Pay Me Later

by *Gretchen Lawrence, BA, RRT, FAARC, NLHEP liaison to the AARC*

As members of the Adult Acute Care Section, those of you reading this article are most likely dealing with life-threatening situations on a day-to-day basis. Why in the world should you be interested in the National Lung Health Education Program (NLHEP)?

Did you know that:

- Smoking is listed as a factor in stroke, cancer and heart disease?
- At least 20% of smokers will develop airflow limitations that will impact their quality of life?
- Spirometric abnormalities predict all-cause mortality?

The NLHEP guidelines strongly suggest that the first line of defense is a good offense - and that the primary care physician (PCP) is in the best position to identify and treat these patients early in the course of their disease, many times long before they present with symptoms. The evaluation process begins with a few simple questions:

- Are you 45 or older and/or have a smoking history or environmental exposure?
- Do you have a chronic cough, sputum production and/or shortness of breath?

If the patient answers "yes" to any one of these questions, he/she should have a simple spirometry test - a test that can and should be performed in the PCP's office. And the only numbers that the doctor needs to interpret are the FEV1, FEV6 and the ratio between the two. As always, good patient effort and reproducibility are the keys to validity.

So why should this interest you, the acute care therapist? Because it is a case of, "pay me now or pay me later." You will see this patient eventually. Wouldn't you like to play a role in impacting that patient's care long before he/she gets to you? Encourage the doctors you work with to become familiar with the NLHEP guidelines. Become a NLHEP "expert" and share the literature with them. Help develop and implement a smoking cessation program in your hospital. Put the following on your "read and save" list:

- The Lung Health Study. *JAMA* 1994;272:1497-1505.
- Strategies for Preserving Lung Health and Preventing COPD and Associated Diseases. The National Lung Health Education Program. *Chest* 1998;113(2Suppl): 123S-163S (reprinted in *RESP CARE*, 1998;43[3]).
- Petty TL. Simple Office Spirometry. *Clinics in Chest Medicine* 2001;22(4).

Find out more about NLHEP and what it is trying to achieve by visiting the NLHEP web site at www.nlhep.org. Or contact me directly at gl-lungs@swbell.net. Together, we can make a difference! ♦

Appearing Live in the ICU...

Busy ICUs are generally full of sounds - health care professionals conversing, alarms sounding, equipment being pushed to and fro - but rarely does anyone hear the sounds of live entertainment.

That's not the case at the University of Alabama at Birmingham Medical Center. The ICU there is regularly visited by the hospital's board-certified music therapist, who loads up her cart with musical instruments and activities and visits patients throughout the unit. According to Sunny Hadder, "It's much more than merely singing to a patient, and it does a lot more than entertain." Research, she says, indicates music therapy helps patients talk about their illness; makes them more relaxed, raises comfort levels; reduces blood pressure, pain perception, fear, stress and anxiety; and increases feelings of self-worth and control. ♦

The AARC Needs You!

Did you know it takes more than 500 active volunteers to successfully run the vast and varied programs and services offered by the AARC every year? Who should take on these responsibilities? How about you?

President-elect David Shelledy, PhD, RRT, is currently seeking volunteers to serve on various AARC committees and in numerous other capacities during his presidency in 2003. If you'd like to sign up - or just find out more about how you can become more involved in your professional association - check out the following link on AARC Online: aarc.org/headlines/volunteer. ♦

NOTES FROM THE EDITOR

Keith asked in his article how we would have treated the patient differently at our institutions. At my institution we would have perhaps nebulized Prostacyclin rather than used nitric oxide. We wouldn't have used TGI. THAM may have been given instead of bicarb. My default approach would have been to stick with a very rapid form of APRV (pressure low set at zero) and reduce mean airway pressure just below where it adversely affected preload.

If you'd like to weigh in on Keith's study, share your thoughts with fellow members by posting them on the Adult Acute Care Section listserve. (And if you have yet to sign up for the listserve, please do so ASAP - just go to the section homepage on www.aarc.org and follow the directions there.)

On another note, there are changes afoot with the Bulletin. Beginning next year, the newsletter will be published on a quarterly, rather than bimonthly, basis. At the same time, the AARC will be enhancing the information and materials available to us in electronic format, through our listserve and via our homepage on the Association web site.

This presents many opportunities for our section, but how far we will be able to go with them depends at least in part on our ability to maintain a high number of members. The following list represents my thoughts on the matter, and I'd love to hear yours as well.

- Allow all AARC members to join one Specialty Section for free with basic AARC membership. As most RTs work in adult acute care, this would create a hefty increase in membership for our section.
- Establish a "Protocol Swap Shop" on the Adult Acute Care homepage. Protocols and/or policy/procedure guidelines for such things as nebulized Prostacyclin or teaching autogenic drainage could be shared among clinicians. The series of "Ventilation for Life" articles from past AARC Times could be archived there as well, along with other resources.
- For members who opt to receive the Bulletin as a PDF file attachment to an email (see the Section Connection area in this issue for more on this option), we could also include a set of links to both regular and established URLs (*AARC Times*, *RESPIRATORY CARE Journal*) as well as new URLs deemed beneficial to members. ♦

HIPPA Regulation Finalized

After several years of debate, a final rule governing the privacy of medical records was published in the Federal Register August 14. The regulation, established by the Health Insurance Portability and Accountability Act, includes the following provisions:

- Patients must give specific authorization before entities covered by this regulation could use or disclose protected information in most non-routine circumstances - such as releasing information to an employer or for use in marketing activities. Doctors, health plans and other covered entities would be required to follow the rule's standards for the use and disclosure of personal health information.
- Covered entities generally will need to provide patients with written notice of their privacy practices and patients' privacy rights. The notice will contain information that could be useful to patients choosing a health plan, doctor or other provider. Patients would generally be asked to sign or otherwise acknowledge receipt of the privacy notice from direct treatment providers.
- Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before sending them marketing materials. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.
- Specifically, improvements to the final rule strengthen the marketing language to make clear that covered entities cannot use business associate agreements to circumvent the rule's marketing prohibition. The improvement explicitly prohibits pharmacies or other covered entities from selling personal medical information to a business that wants to market its products or services under a business associate agreement.
- Patients generally will be able to access their personal medical records and request changes to correct any errors. In addition, patients generally could request an accounting of non-routine uses and disclosures of their health information.

The regulation will go into effect for most entities on April 14, 2003. ♦

Joint Commission Announces 2003 National Patient Safety Goals

The Joint Commission on Accreditation of Healthcare Organizations has announced its first set of six National Patient Safety Goals. Health care organizations will be surveyed on the following goals beginning in January:

Improve the accuracy of patient identification.

- Use at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products.
- Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active - not passive - communication techniques.

Improve the effectiveness of communication among caregivers.

- Implement a process for taking verbal or telephone orders that require a verification "read-back" of the complete order by the person receiving the order.
- Standardize the abbreviations, acronyms and symbols used throughout the organization, including a list of abbreviations, acronyms and symbols not to use.

Improve the safety of using high-alert medications.

- Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
- Standardize and limit the number of drug concentrations available in the organization.

Eliminate wrong-site, wrong-patient, wrong-procedure surgery.

- Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
- Implement a process to mark the surgical site and involve the patient in the marking process.

Improve the safety of using infusion pumps.

- Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

Improve the effectiveness of clinical alarm systems.

- Implement regular preventive maintenance and testing of alarm systems.
- Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit. ♦

NOVEMBER IS COPD AWARENESS MONTH

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Public Approves of Hospitals

Most Americans believe hospitals are doing a good job of serving their communities - and a much better job than HMOs. These findings come from a new Harris poll conducted among more than 1000 adults nationwide. Nearly three-quarters said hospitals are serving their customers well, as opposed to 33% who said HMOs are doing the same. The hospital approval rating is 6% higher than the rate found during a similar poll conducted last year. ♦

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ADULT ACUTE CARE SPECIALTY PRACTITIONER THE YEAR: KEITH LAMB, RRT

case study on abdominal compartment syndrome, a complication those of us at the bedside need to be aware of. The article provided a wonderful, concise review of the disease process, the diagnosis, and the treatment required. In the last issue, he followed up with another great case study, this time on gas exchange in a patient in extremis.

In researching this nomination, I had the pleasure of speaking with Keith's manager, John Emberger. John told me of Keith's rapid rise to the position of night shift charge therapist, partially due to his ever-expanding knowledge base, and partially due to his quiet, confident leadership skills. John also told me he sleeps better at night knowing that Keith is at work to assist with the set up of some of the more rare and exotic procedures that find their way to the busy teaching ICUs at their hospital. Keith is well known as a resource, not only for his fellow therapists, but for the house staff as well.

Keith has demonstrated the level of professionalism, the thirst for knowledge, and the leadership skills that are embodied in the best of our bedside professionals. We are truly honored to be presenting him with this award, which he will receive during the Awards Ceremony at the AARC Congress this October. ♦