Management Bulletin
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American Association for Respiratory Care

Considerations for Involving Respiratory Therapists in Conscious Sedation

by George Gaebler, MS Ed, RRT, director of respiratory care and cardiovascular service line administrator, University Hospital, Syracuse, NY

Respiratory care departments at several hospitals across the country have become involved in providing conscious sedation and conscious sedation monitoring for patients under their care. It is important for anyone who may be considering providing these services to distinguish between the monitoring of conscious sedation and the provision of conscious sedation. In states with licensure or certification laws on the books, you will want to check with the Licensure Board to determine the extent to which respiratory care personnel can provide conscious sedation. In states without such laws, you need to consult with the state health department, which probably regulates the provision of drug therapies such as conscious sedation.

In New York State, we have a licensure law that provides fairly clear delineation as to the role that can be performed by the respiratory therapist. There is clear indication that respiratory therapists are able to provide conscious sedation drugs to patients under their care for respiratory-related diseases. An example would be a patient undergoing bronchoscopy when the respiratory therapist is involved in the procedure. It is probable that most states would allow RTs to be involved in protecting the airway of conscious sedation patients, as protecting the airway is fairly common practice for RTs, without considering the fact that it may be for conscious sedation purposes.

One reason why respiratory therapists are being asked in many hospitals to consider provision and monitoring activities for conscious sedation is the shortage of registered nurses to perform these activities. However, at least in Central New York, there is currently a shortage of respiratory therapists as well, which makes the substitution of RTs for RNs not as easy as it was even a year ago. Any department considering the monitoring or provision of conscious sedation would want to consult with members of the anesthesia team, perioperative team, and probably the pain management team. These groups would be available to provide input to protocols for conscious sedation which probably are already in place at your institution.

Basic considerations for conscious sedation monitoring

The respiratory therapist needs to be free to monitor the patient on a regular basis, preferably every 15 minutes or so to assure that the patient's airway is intact and protected during sedation. Obviously, patients who are on mechanical ventilation do not fit the definition for conscious sedation because, in reality, their airway is already protected.

The person providing conscious sedation monitoring should be in addition to the individual — usually an RN or physician — who is actually providing the sedation medication.

Basic considerations for provision of conscious sedation

Develop a list of approved medications for conscious sedation through a task force made up of anesthesia, perioperative, nursing, and pain management folks, along with the respiratory therapy department from your hospital.

Respiratory therapy staff will probably need training, education, and credentialing in the insertion, maintenance, and management of IVs, and the provision of analgesics. As indicated earlier, they will also need to be available to the patient for provision of this therapy.

It must be noted that any protocol that is developed should include distinguishing characteristics that describe the levels

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of sedation beyond what is considered conscious sedation. The American Society for Anesthesia has solid definitions in this area and will provide most of the guidance on what constitutes conscious sedation and what constitutes deep sedation, which really requires anesthesia in attendance.

Some of the specific considerations that fall into this area are services where patients are being sedated fairly deeply for cardioversions, electrophysiology procedures, and other cardiology procedures. You may find that this is a gray area for individuals within your hospital and that people outside the anesthesia department are providing this deep sedation without proper credentialing. This can create problems with regulating agencies, such as the Joint Commission on the Accreditation of Healthcare Organizations.

One of the best outcomes from the provision of conscious sedation and conscious sedation monitoring by the respiratory therapy department is the firm establishment of respiratory therapists as team providers in other high tech areas. RTs are recognized for their skills in the management of the patient beyond the typical duties associated with the field.

For more information about the provision of conscious sedation and conscious sedation monitoring by RTs, contact George via e-mail at gaeblerg@upstate.edu or phone at (315) 464-4490. ■

The Word on the Web

What are RT managers talking about these days? A good way to find out is to sign up for the Management Section listserv, available to section members on AARC Online (www.aarc.org). To give you an idea of some of the information circulating among members on the listserv, we are beginning a new section in the *Bulletin* containing some "sounds bites" from various discussions. In order to ensure the ongoing free exchange of information and the privacy of all concerned, all names have been omitted. Postings have also been edited slightly for space and style considerations.

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American Association for Respiratory Care
11030 Ables Lane
Dallas, TX 75229-4593
(972) 243-2272
FAX (972) 484-2720
e-mail: info@aarc.org

Kelli Hagen
AARC communications coordinator

Debbie Bunch
Bulletin managing editor

Edwards Printing
Bulletin typesetting

Section Chair
Karen Stewart, MS, RRT
(304) 348-4367
karen.stewart@camcare.com

Bulletin *Editor*
John D. Kimble, Jr. , RRT, RCP
Director, Respiratory Care Services & Sleep Diagnostic Lab
Scott & White Memorial Hospital
2401 S. 31st St.
Temple, TX 76508-0001
(254) 724-2179
FAX (254) 724-7630/724-7572
jkimble@swmail.sw.org

Chair-elect
Garry Dukes, BS, RRT
(704) 355-2377

Medical Advisor
Martin Sheridan, MD (ACCP)
(410) 682-7626
FAX (410) 682-8044

Tracking E cylinders

Manager #1: I have a student who is doing a management project for me. Her manager asked her to find out how other facilities are handling the tracking of missing E cylinders. It seems that the problem is greatest in hospitals that have more than 150 beds, but I'm not sure. I would appreciate any responses and solutions.

Manager #2: We are an 80-bed facility and trust me, the size doesn't matter. We found the biggest culprits to be the nurses. When a patient is discharged, our SS/DP department orders the home oxygen. When the patient went home, our portable E cylinder went home with them. So, we inserviced our nurses and SS/DP staff that when a patient is discharged and will need oxygen for transport, they can (a) have the DME provider come in and drop a cylinder off for the patient or (b) have the DME provider make arrangements with us to return the cylinder on the SAME DAY. We note the number on the gauge prior to transport. Since then there have been fewer problems. Of course, we always find E cylinders in other places, especially in diagnostic areas.

Manager #3: Yes, we have a problem with missing tanks. We are a 550-bed institution. We've tried multiple plans — none have been successful. They simply disappear.

Manager #4: Because oxygen can only be billed out as a supply item, we moved the responsibility of E's to central supply. CS now checks and stocks the floors with E's. Each nursing station is assigned the appropriate number of tanks and is responsible for its own tanks. The carts are color-coded so each nursing station can recognize its own tanks. If they lose a tank and it can't be found in the system, CS issues them a new one and bills that department for the replacement. It was amazing how nursing all of a sudden took very good care of their tanks. The problem has all but gone away.

Manager #5: The best thing I ever did to keep up with the oxygen tanks was to make each floor or department that wanted/needed an O_2 tank responsible for the purchasing of the gauge and push cart. We will change the tank, but the area that the tank stays in is responsible for the equipment. This means when they break it or lose it they have to explain why and come up with the dollars for replacing/repairing. I do not even keep loaners; they have to get one from whoever is repairing theirs.

So far this has really helped cut down on breakage and lost O_2 tanks and gauges.

Manager #6: We are a 300-bed facility and have NO IDEA where they go! Maybe the same place as the missing resuscitator bags? We tried color-coding, thinking that someone was taking the med/surg cylinders and hoarding them elsewhere, but all the colored regulators disappeared! Our home care companies are really good about getting oxygen here before discharge, so that doesn't seem to be our answer. Personally, I think there must be a great market out there for E cylinder regulators!

Manager #7: We are a 350-bed facility, with another 100-bed hospital across town. I'm not sure what the issue is — not having cylinders available when needed, or the expense of replacing/renting cylinders that "walk." We struggled (without success) for years with this problem (the latter one). Every few years we had to sit down with the vendor and discuss (argue) about how many cylinders we were being charged for. This may not be the solution you were looking for, but last year I purchased 750 cylinders for the system and eliminated all of our small cylinder rental ($6.30 per month per tank). We then got a letter from our vendor acknowledging our purchase of cylinders and agreeing to eliminate the rental charges. The only time there will

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be an accounting for the cylinders is if we ever cancel our contract with them. Essentially, this solution eliminated the need to track cylinders at all, and saved a ton of money in cylinder demurrage charges at the same time. Now, as for always having one available where you need it . . .

Manager #8: You are correct, size of the hospital does not matter! We are a 78-bed facility, and we have a difficult time keeping track of our E-tanks also. We only have three on carts and two mounted on wheelchairs for floor use, and at any given time, at least one is unaccounted for. We have tried . . . charging the floor responsible, but they still turn up missing. Often the cart is there but the tank is gone. Sometimes everything is there, but the regulator is missing or the wrench is gone, even though they are secured with a steel cable! Usually, when they cannot be located and are replaced, the missing one will "reappear" lying on the floor beside the replacement. Of course, "nobody" knows anything about it. Nothing seems to work. Radiology, PT, and recovery room each have their own, so we have just given up on the floor units and keep a "spare" in the department as a replacement if needed. We had one tank/cart that "reappeared" four months later! Perhaps someone will discover a "portal" to a parallel universe which is full of E-tanks (and the single socks missing from home clothes dryers).

Manager #9: We are an 800-bed teaching facility (trauma center, NICU, PICU, open heart, on and on . . .) but are dealing with the same problems as the community hospitals. We have not completely solved the problem, but have improved the associated costs and inconveniences associated with cylinders through the following steps:

- RT rarely uses a cylinder unless transporting an intubated patient, and we have our own stock, with 50 PSIG check valves for our transport ventilators.
- Transportation frequently transports patients requiring low flow O_2 so we gave the lot of cylinder stocking and par levels to them and they take it very seriously.
- Nobody owns their own cylinders. They all belong to the hospital, so par levels are unit specific but not regulator and cart specific.
- Taking a process from the car rental companies, ALL cylinders on transports require a round trip. Even with patients going to the OR, etc., another cylinder is taken by transport from the receiving department's par level to bring back to the sending department. It really works.
- We insist that the vendor provide us with a monthly demurrage report and semiannual cylinder audit.
- We are no longer in the cylinder business.
- We purchased newer generation E regulators that are less likely to leak when left on (we know this never happens), so cylinders contain gas when needed.
- My demurrage expenses were reduced by $46,000 in the first year, and we never get stat cylinder requests because "we can't find ours" or "ours is empty."

Manager #10: We are 325-beds and have the same problems. Each of our nursing units and departments are responsible for their own regulators. We started color-coding about four months ago and this has helped a lot. I'll place the order for new regulators and charge the unit. Allegiance (formerly 3CI) has color-coded regulators for about $75 each, and they come with a 5-year warranty.

Pay scales

Manager #1: We are trying to find out how others are dealing with pay scales, market adjustments, and cost of living increases. We have several people who have maxed out on the pay scale and receive a lump sum check. Do other hospitals do this or do they adjust the pay scale to incorporate the increases?

Manager #2: Here, when you're at the top, you get a lump sum for merit. If you get a market increase you get an increase in the top of your scale.

Manager #3: The employee's percentage increase is calculated based on their evaluation score. If the hourly increase is such that it will put the employee above the maximum allowable salary for that position, they are given the amount below the cap as a salary increase and the balance is calculated as a lump sum. The caps for all positions are readjusted each year based on the government's most recent inflation number. So, if they never change positions, they would get an hourly increase in salary every year as well as a lump sum.

Manager #4: Same here, except we no longer do cost of living increases. We do a market survey every year and do market adjustments to only those classes that are out of the market range. Lump sums apply to those capped out. It's a fairly common practice in the industry. As for pay rate increases (done at the time of the evaluation), that is now based on the performance of the hospital. If we don't make a margin this year, there may be no rate increase in the next year.

Employee recognition

Manager #1: We here in the great white north are looking at various ways to provide employee recognition. Does anyone out there have any great ideas that have worked for them, and if so would you be willing to share?

Manager #1: Here are a few of the things we do to reward our employees:

- Quarterly "Team Spirit" award, with a nice framed certificate and a check for $150. These folks are nominated and voted on by staff. I stay out of it — just provide the dollars.
- I have monthly Team Leader meetings, and employee recognition is the first item on the agenda. Each Team Leader is expected to formally recognize at least one staff member with a letter of appreciation or recognition.
- We just recognized 25 of our night crew with $50 bookstore certificates for enduring the "craziness" of nights.
- We provided all eight of our Team Leaders with their own Palm Pilots in appreciation for meeting our productivity and performance objectives.
- We frequently have awards for participation in programs and just awarded two Palm Pilots and about $200 in gift certificates for participation in our RC Customer Survey program.
- We make sure that RC Week is celebrated on all shifts with catered food, fun, and games, and that the hospital recognizes our staff in a special way.
- We recently implemented our Extra Mile Incentive Program by which staff members earn 5-30 points for doing anything from helping with a student to completing a JCAHO prep module. RCPs can use these points to purchase supplies, attend advanced training programs, or go to seminars that will help enhance their professional careers. ■

Bulletin Deadlines

Issue	Date editor must have copy
January/February	December 1
March/April	February 1
May/June	April 1
July/August	June 1
September/October	August 1
November/December	October 1

ORYX Data Collection Begins Next Summer

Hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will be expected to begin collecting data on the first sets of the ORYX® core performance measures on July 1, 2002. The new timeline was approved by the Board of Commissioners at its May 11 meeting.

The July 1, 2002 target date represents an extension of six months from the original target date.

This timing is intended to allow hospitals and performance measurement systems sufficient time to plan and budget for activities related to the collection of core measure data. The Joint Commission's Core Measures Implementation Task Force, composed of members of state hospital associations and chaired by Gary Carter, president and CEO of the New Jersey Hospital Association, suggested the modified schedule.

Key dates in the revised core measure implementation schedule include the following:

- **April 2001:** Joint Commission released to participating measurement systems the preliminary technical specifications for all core measures.
- **October 2001:** Joint Commission releases final technical specifications for initial measure sets.
- **November-June 2002:** Hospitals formally select core measure sets based on the health care services that they provide.
- **July 2002:** Hospitals begin data collection.
- **January 2003:** Joint Commission receives first core measure data for the July 1 to September 30, 2002 quarter. The due date is four months from the end of the last month of the reporting quarter.

Implementation of standardized core measures has long been a key objective of the Joint Commission's ORYX® initiative, which eventually seeks to integrate outcomes and other performance measurement data into the accreditation process. "The goal is to ensure a continuous, comprehensive, data-driven accreditation process that brings value to all stakeholders by focusing on those processes of care that have been linked to good outcomes," says Jerod M. Loeb, PhD, vice president for research and performance measurement.

The use of core measures will support the Joint Commission's mission to improve the safety and quality of health care provided to the public by:

- Helping organizations identify issues that require attention.
- Establishing a national comparative database that facilitates benchmarking, accountability reporting, internal quality improvement activities, and health services research.
- Providing a mechanism for monitoring health care organization performance on a continuous basis.
- Focusing on-site evaluation activities on areas of organization performance that represent the greatest opportunities for improvement. ■

Get it on the Web

Want the latest news from the section in the quickest manner possible? Then access the *Bulletin* on the Internet! If you are a section member and an Internet user, you can get your section newsletter a week and a half to two weeks earlier than you would get it in the mail by going to your section homepage at: http://www.aarc.org/sections/section_index.html. You can either read the *Bulletin* online or print out a copy for later.

The AARC is encouraging all section members who use the Internet to opt for the electronic version of the *Bulletin* over the mailed version. Not only will you get the newsletter faster, you will be helping to save the AARC money through reduced printing and mailing costs. These funds can then be applied to other important programs and projects, such as ensuring effective representation for RTs on Capitol Hill.

To change your option to the electronic section *Bulletin*, send an email to: mendoza@aarc.org. ■

Experience the Best of the Science, Tradition, and Future of Respiratory Care

28th Annual Donald F. Egan Scientific Lecture

COPD — On the Exponential Curve of Progress

John Heffner, MD, of Medical University of South Carolina will address COPD and its growing significance for respiratory therapists.

16th Annual Phil Kittredge Memorial Lecture

Mechanical Ventilation: How Did We Get Here and Where Are We Going?

Among therapists, Rich Branson, RRT, FAARC, of the University of Cincinnati Medical Center, is well recognized as an authority and visionary when it comes to mechanical ventilation.

27th Annual OPEN FORUM

Hundreds of original research papers will be showcased over the four days of the Congress, reviewing the latest in pediatric, adult, critical care, home care, and education. (You can still submit your research project — deadline July 31). Learn about cutting edge research in the OPEN FORUM and see the latest technology in the Exhibit Hall.

17th Annual New Horizons Symposium

This year the topic is airway clearance techniques. This featured symposium attracts an audience of hundreds who come to immerse themselves in the most thorough review of a clinical topic.

Secure your early bird low-cost registration fee now! Register online at www.aarc.org. Also, continue checking the AARC website for the latest information on the Congress.

The AARC's International Respiratory Congress is the gold standard of respiratory care meetings. The Congress boasts:

- The lowest cost of continuing education per credit of any show, anywhere.
- The largest and most impressive exhibit hall with the most vendors, where you can make your best deals on major purchases AT THE SHOW!
- The largest gathering of respiratory care experts and opinion-makers in the world.
- The most diverse and most dynamic series of lectures.
- The most opportunities for YOU to participate in your profession through research and networking. ■

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http://aarc.org/sections/section_index.html

JCAHO Accreditation Report

The AARC is currently seeking information on JCAHO accreditation site visits. Please use the following form to share information from your latest site visit with your colleagues in the Association. The information will be posted immediately on the AARC web site at http://www.aarc.org/members_area/resources/jcaho.html and will also be featured in the *Bulletin*.

Accreditation visit you are reporting (choose one):

❏ Home Care
❏ Hospital
❏ Long Term Care
❏ Pathology & Clinical Laboratory Services

Inspection Date: _____

Facility Name:_____

Contact: _____
(Please provide name and e-mail address.)

1. What was the surveyors' focus during your site visit?_____
_____
_____
_____

2. What areas were cited as being exemplary?
_____
_____
_____

3. What suggestions were made by the surveyors?
_____
_____
_____

4. What changes have you made to improve compliance with the guidelines?
_____
_____
_____

Additional comments:
_____
_____
_____
_____

Mail or fax your form to:
William Dubbs, RRT
AARC Associate Executive Director
11030 Ables Lane
Dallas, TX 75229
FAX (972) 484-2720

Specialty Practitioner of the Year

Don't forget to make your nominations for the 2001 Management *Specialty Practitioner of the Year.* This honor is given to an outstanding practitioner from this section each year at the AARC's Annual Convention.

The recipient of this award will be determined by the section chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the section.

Use the following form to send in your nominations for this important award:

I would like to nominate ____________________________ for Management *Specialty Practitioner of the Year* because ____

Nominee	***Your Name***
Hospital	Hospital
Address	Address
City State, Zip	City State, Zip
Phone	Phone

Mail or FAX your nomination to the section chair at the address/number listed on page 2 of this issue.