American Association for Respiratory Care's

Management Bulletin

May / June 2002

Notes from the Chair

by Karen Stewart, MS, RRT

As I write this column in early April, the AARC is in the process of releasing its white paper on concurrent therapy. If you have yet to learn about this important paper, read the article in this issue and then visit the AARC web site (www.aarc.org) to access the paper itself. After you've digested the contents, email me with your comments. If I receive enough responses, I'll share your thoughts with the readership in the next Bulletin.

The AARC's release of this white paper is particularly timely now, as the July 1 implementation of the new JCAHO staffing effectiveness standards nears. These standards (see adjacent article for the complete list) are very different from any we have seen in the past. Basically, health care facilities are now being asked to correlate staffing levels to human resource and clinical indicators and determine if there is a relationship between the two. The standards are based on a pilot study involving 43 hospitals nationwide.

The most widely used clinical indicators were:

- Patient fall rates
- Adverse drug events
- Patient complaints
- Pressure ulcers

The most widely used HR indicators were:

- Hours per patient day
- Overtime
- Staff turnover
- Understaffing relative to plan

The Joint Commission created the staffing effectiveness standards to address the fact that staffing has a direct impact

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Section Connection

GET IT ON THE WEB:
Help the AARC increase its efficiency by signing up to receive the Bulletin via the section homepage on the AARC web site (www.aarc.org). To change your option to the electronic Bulletin, send an email to: mendoza@aarc.org.

JCAHO ACCREDITATION REPORT:
Please consider sharing information about your most recent site visit by filling out the form on the AARC web site found at the following link: www.aarc.org/members_area/resources/jcaho.asp.

SECTION LISTSERVE:
Start networking with your colleagues via the section listserve. Go to the section homepage on www.aarc.org and follow the directions to sign up.

JCAHO Staffing Effectiveness Standards

The new JCAHO staffing effectiveness standards, published in the latest update of the JCAHO manuals, are as follows:

Standard HR.2.1

The hospital uses data on clinical/service screening indicators in combination with human resource screening indicators to assess staffing effectiveness.

Intent of HR.2.1

- Multiple screening indicators that relate to patient outcomes including clinical/service and human resources screening indicators, looked at in combination, may correlate with staffing effectiveness.
- A minimum of four screening indicators, two clinical/service and two human resource, are selected. The focus is on the relationship between human resource and clinical/service screening indicators, with the clear understanding that no one indicator, in and of itself, can directly correlate with staffing effectiveness.
- At least one of the human resource and one of the clinical/service screening indicators are selected from a list of Joint Commission-identified screening indicators. Additional screening indicators are identified by the hospitals to recognize the hospital's unique characteristics, specialties and services.
- Rationale for screening indicator selection is determined by the hospital. Both direct and indirect caregivers are included in the human resource screening indicators. Hospitals define which caregivers are included in the human resource screening indicators based upon what impact, if any, the absence of such caregiver is expected to have on patient outcomes.
- The data collected and analyzed from the selected screening indicators is used to identify potential staffing effectiveness issues.
- A process is established to analyze screening indicator data over time per measure (for example, target ranges, trends over time, stability of process, external comparison data) and then in combination with other screening indicators (such as, matrix report, spider diagram, radar diagram, statistical correlations).
- Screening indicators are analyzed at the level most effective for planning staffing needs in the hospital and in collaboration with other areas in the hospital, as needed.
- The hospital reports at least annually to the leaders on the aggregation and analysis of data related to the effectiveness of staffing (PI.3.1.1) and any actions taken to improve staffing.
- There is evidence of action taken, as appropriate, in response to analyzed data.

Screening indicators

- Overtime (HR)
- Family complaints (C/S)
- Patient complaints (C/S)
- Staff vacancy rate (HR)
- Staff satisfaction (HR)
- Patient falls (C/S)
- Adverse drug event (C/S)
- Staff turnover rate (HR)
- Understaffing as compared to organization's staffing plan (HR)
- Nursing care hours per patient day (HR)
- Staff injuries on the job (HR)
- Injuries to patients (C/S)
- Skin breakdown (C/S)
- On-call or per diem use (HR)

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Swap Shop Guidelines

In order to make the Swap Shop on the Management Section homepage of the AARC web site (www.aarc.org) more useful for us all, the section has developed the following guidelines for posting of materials:

1. Material submitted to the swap shop should be generic in nature, allowing the end user the ability to use the information with little or no editing.

2. Forms, checklists and data that are submitted as "management tools" should include adequate information/ instructions so that end users can easily apply the tool in their own facilities.

3. Any material submitted must meet clinical practice guidelines or be evidence-based, reflecting standards and methods that are well supported.

4. Material that references any publication should include a bibliography so the evidence-based source can be obtained.

5. Material that references another policy and/or procedure must include that policy and/or procedure.

6. Generic terms such as "assessment" must be well defined, and elements in the assessment must be included in the submission.

7. When using term such as "within normal limits," "as tolerated," "per criteria," etc, these terms must be clearly defined.

8. Submissions to the Swap Shop must meet these criteria; in addition they should contribute a unique value to the respiratory care community as determined by the Submission Review Board. ◆

Want to receive this newsletter electronically?

E-mail: mendoza@aarc.org for more information.

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

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

Editor
John D. Kimble, Jr., RRT, RCP
jkimblerrt@aol.com

AARC Takes on Concurrent Therapy

The AARC is giving us the resources we need to combat the problem of concurrent, or stacked, therapy in our departments. Last spring, the Association released a groundbreaking white paper outlining the patient safety hazards inherent in this process.

The paper states: "Patient safety is the primary reason for respiratory therapists not to deliver care via concurrent therapy without a thorough patient assessment. Indiscriminate use of concurrent therapy may lead to declines in quality and may jeopardize patient safety. Aerosolized medications administered during treatments have potential adverse reactions. Recognition of these reactions is not possible if the patient is left unattended and thus a safety hazard exists."

The white paper identifies protocols as one of the best means of bringing efficiency to the system in order to eliminate concurrent therapy practices. The Association is urging respiratory care departments to develop policies and procedures to govern the practice of concurrent therapy. "Ultimately, it is the ethical and professional responsibility of respiratory therapists to assure their patients receive both safe and effective care of the highest quality," says the paper. ◆

Word on the Web

This issue, we feature sound bites from discussions on the Management Section listserve regarding EKGs and "patient care assistants." Postings have been edited for space and style considerations.

RTs and EKGs

Manager #1: How many departments have respiratory therapists doing EKGs? It seems we are being requested to do more and more of them.

Manager #2: My department does all the EKGs in the hospital. This is definitely job security, but it can cause problems when you are being drawn in several different directions at once.

Manager #3: We are a full cardiopulmonary department and do all of the EKGs, Holters and stress tests. We also get the revenue for doing them and extra staff. All of the staff members are cross-trained to do respiratory and cardiac, so job security is GREAT.

Manager #4: During the downsizing of the early 1990s my RT department absorbed the EKG department and its duties. After all these years, it's just part of the job. Oh, yes - there is job security as a byproduct.

Manager #5: We took on all inpatient EKGs about four years ago, doing a volume of about 300 per month in our 400-bed medical center. My position with administration is that I will take on any service within our scope of practice that adds some benefit and is integrated into our productivity system with a mutually agreed upon time standard.

PCAs

Manager #1: Our administration is looking at hiring PCAs (patient care associates) to perform unlicensed duties such as nurse aide duties, EKGs, phlebotomy, arterial sticks, etc. Does anyone have any experience with this concept?

Manager #2: The ABG is considered a moderately complex test by CLIA, so even if you're in a state that doesn't have licensure, someone trained on the job would be prohibited from doing them.

Manager #3: I can see using PCAs for EKGs, phlebotomy and a few other non-technical procedures. I, personally, would have a real problem with arterial sticks. This is a complicated procedure as it is, and the risks are too high for this procedure to be given to PCAs.

Manager #4: We have patient care associates. They are assigned to the medical unit, surgical unit and a few other departments. They DO NOTdo anything clinical. We have kept these duties to maintain continuity and competency in our department.

Manager #5: Most ABGs involve manipulation of a patient's oxygen or vent settings. An unlicensed PCAwould clearly be prohibited under the respiratory therapy licensure law in this state from adjusting either of these and would clearly be a danger to the public. That is why we have a license. ◆

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Quick Polls

Two informal surveys were recently completed via listserves on the AARC web site. AARC Associate Executive Director Bill Dubbs, MHA, RRT, polled members of the Management and Diagnostics Sections about the involvement of respiratory care departments in sleep studies, and Larry Spurgeon, RRT, RPFT, director of respiratory care at Henry County Memorial Hospital in New Castle, IN, asked Management Section members about their use of pediatric mist tents. Here are the results of these quick polls:

Sleep studies (100 respondents)

Does the respiratory therapy manager have oversight of sleep studies in your facility?

YES: 73%

NO: 22%

Pediatric mist tents (43 respondents)

Do you still use pediatric mist tents at your hospital?

YES (actively using): 60%

Available, but not used in 1+ year: 14%

NO: 26% ◆

In Their Hands

The growing shortage of qualified health care professionals has raised concerns among everyone from the general public to Congress. Now a groundbreaking new report from the American Hospital Association is calling on hospital CEOs to take aggressive action.

"While society has significant responsibility for dealing with this crisis, this report - *In Our Hands* - recommends bold, innovative changes that hospitals and their leaders must make in order to avert limitations in necessary health care services now and in the future," says the Executive Summary. Among the actions needed: make health care work more meaningful, reward front-line workers and increase compensation packages, develop a more diverse workforce, build strong relationships with colleges and universities, work more closely with professional associations, and encourage all payers to contribute to workforce development. ◆

Worker Shortage Hits Georgia Hard

A new survey conducted by the Georgia Hospital Association (GHA) indicates respiratory therapists and other allied health practitioners are in short supply in the state. The survey, conducted last fall among 125 hospitals, found a 40% increase in allied health vacancies over the previous two year period and a 38% jump in nursing-related vacancies. According to the GHA, more than 1400 budgeted positions in allied health fields like RT, pharmacy, and radiographic technology remain unfilled. ◆

AHA says Hospitals Not Out of the Woods Yet

Medicare cuts are still taking their toll on America's hospitals, despite recent efforts by Congress to restore some of the lost payments. According to a new report from the American Hospital Association, 58% of hospitals are losing money on their Medicare patients, 34% are losing money on inpatient Medicare services and 32% have negative total margins.

The report, "The State of Hospitals'Financial Health," goes on to predict that hospitals will continue to feel the financial fallout from caring for Medicare beneficiaries, with the number losing money on these patients growing to nearly 65% by 2005. ◆

CRCE Online: Click Here, You're There!

Don't forget that your staff can pick Continuing Education credits by logging into CRCE Online at the AARC web site. AARC members receive the highest discounts and have their credits tracked for them through CRCE. Anywhere, anytime, your staff can access quality continuing education at www.aarc.org. Call Sherry Milligan at 972-243-2272 for information on discounts for group CRCE Online purchases. ◆

New JCAHO Initiative Targets ICU quality

The Joint Commission is working with the Leapfrong Group to identify a basic set of outcomes-based measures for assessing the quality of hospital intensive care units. The organization plans to convene an expert panel to determine an ICU measurement framework and formulate an initial set of specific performance measures. As part of this process, JCAHO is issuing a call for existing measures that address care in medical, surgical and medical/surgical intensive care settings. To submit potential sources of ICU core measures, visit the Joint Commission's web site at www.jcaho.org /perfmeas/coremeas/cm_frm.html, or contact Nancy Lawler, associate project director, at (630) 792-5937 for additional information. ◆

JCAHO Moves Forward on Patient Safety Goals

A new Joint Commission advisory group met in mid-April to begin work on the first set of National Patient Safety Goals being developed by the JCAHO for implementation next year. Named for the Joint Commission's widely read periodic patient safety advisory, the *Sentinel Event Alert*, the Sentinel Event Alert Advisory Group will initially conduct a thorough review of all existing *Alert* recommendations and identify those that are candidates for inclusion in the annual *National Patient Safety Goals*.

The first set of six National Patient Safety Goals will be announced in July, and health care organizations will be surveyed for compliance beginning in January of 2003. ◆

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: www.aarc.org/headlines/volunteer. ◆

SPECIALTY PRACTITIONER OF THE YEAR:
Submit your nominations online at: www.aarc.org/sections/mgmt_section/mpotya/poll_form.html

American Association for Respiratory Care
11030 Ables Lane
Dallas, Texas 75229-4593

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Dallas, Texas

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NOTES FROM THE CHAIR

on quality and safety of care and to respond to legislative attempts to improve patient outcomes through mandated staff-to-patient ratios. The staffing effectiveness approach is an attempt to use evidence as a basis to approach the standard and acknowledges that no single factor can describe staffing effectiveness. The indicators are to be used as screening tools for potential staffing issues, and variations should create further detailed analysis.

I invite you to share your staffing effectiveness model with the members of the section, either through the Bulletin or via the section's listserve on the AARC web site. If your hospital is among the first to have a JCAHO visit in the next few months, I would also like to invite you to share your experience in the scoring of the model you used. ◆

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JCAHO STAFFING EFFECTIVENESS STANDARDS

- Sick time (HR)
- Pneumonia (C/S)
- Postoperative infections (C/S)
- Urinary tract infection (C/S)
- Upper gastrointestinal bleeding (C/S)
- Shock/cardiac arrest (C/S)
- Length of stay (C/S)

Other standards that will be scored with HR.2.1

• PI 4.3 if analysis does not occur regarding undesirable patterns or trends in performance of the screening indicators.

• IM 3 will be scored if there are not data definitions across the organization and each indicator has not been defined using a numerator and denominator statement or a description of the population to which the measure is applicable.

• LD 4.3 will be scored if there is a lack of indicator identification, data collection, analysis and/or collaboration within the organization or there is evidence that there are no resources provided for collection of data, the assessment of trends and variation from expected, or for the implementation of appropriate action plans. Or, there is an evidence of a lack of communications between appropriate departments as needed related to the selection, collection, analysis and response to indicator data.

For more on the new standards, go to the following link on the Joint Commission web site: http://www.jcaho.com/standards_ frm.html. Then click on "Standards Revision for 2002" and then on "Revisions Addressing Staffing Effectiveness" (near the end of the page). ◆