Management Bulletin
Sept./Oct. '01

American Association for Respiratory Care

Notes from the Chair

by Karen Stewart, MS, RRT

I have a couple of items to share with you in this *Bulletin*:

Swap Shop

As I write this column in mid-August, there are 25 items posted in the swap shop. The following categories are populated:

Benchmarking: 2
Policies and Procedures: 5
Protocols and Pathways: 4
Recruitment and Retention: 3
Staffing and Productivity: 9
Other: 2

If you have not already done so, I would encourage you to visit the site. You can get there by visiting www.aarc.org, selecting "Communities" from the side bar, and then selecting "Specialty Sections." From there, click on "Management," enter your membership number and you are on the management home page. If you scroll to the bottom you will find the swap shop. While visiting I would also encourage those of you who are not members of the listserv to please consider joining. It is a great way to ask a question and get an almost immediate response from colleagues around the country. ■

JCAHO

The Joint Commission on Accreditation of Healthcare Organizations continues to be a real concern for managers. I will be working shortly to update the JCAHO cross walk with recommendations on how to meet the new standards. Areas that are causing the most concern are pain management and assessment of pain, staffing management, questions about the delivery of concurrent therapy, missed or late treatments, and response to JCAHO advisors.

John Walsh, of DeKalb Medical Center in Decatur, GA, provided me with some information regarding concurrent therapy delivery that was recently published by the JCAHO's Accreditation Connection. According to Darla J. Farrell, RN, BS, MBA, CHE, and John R. Rosing, FACHE, MHA, "the stacking of treatments or providing more than one treatment at a time is a troublesome spot for respiratory departments . . . If you are stacking treatments you should have a clinical justification why you are doing so. Note this in your treatment plan . . . If you are stacking treatments to meet the convenience needs of your respiratory staff, that would be inappropriate. Although no standard exists that specifically says you should not stack treatments, you should not deviate from your standard of care."

John also shared the experiences of a manager who was recently cited by JCAHO for stacking therapy. Recently, Centers for Medicare and Medicaid Services (CMS) (formerly HCFA) requested information regarding this practice. The AARC has responded with the following:

The American Association for Respiratory Care (AARC) submitted comments on the SNF PPS proposed rule, published in the May 10, 2001, Federal Register. The AARC is submitting additional comments to address the issue of concurrent therapy that was raised in the proposed rule. The AARC is a national professional association representing approximately 35,000 respiratory therapists who practice in all health care settings, including SNFs.

While the AARC raised concerns over the method of introducing the issue of concurrent therapy in the proposed rule, it is an issue of great concern to the Association and its members. The AARC commends the Centers for Medicare and Medicaid Services (CMS) for exploring this issue, its impact upon the quality of patient care, and its cost to the Medicare program.

Concurrent therapy as described in the proposed rule is "the practice of one professional therapist treating more than one Medicare beneficiary at a time — in some cases, many more than one individual at a time." In the area of respiratory therapy, concurrent administration of procedures such as aerosol medication delivery, lung expansion therapy, postural drainage, and other bronchial hygiene techniques by a single

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respiratory therapist raises concerns about patient safety and quality of care.

Many respiratory therapy directors have experienced pressure to provide respiratory therapy with fewer staff in an effort to decrease labor costs. Concurrent therapy or "stacking treatments" is one strategy. This practice marginalizes the skills required to deliver effective care. During the course of therapy, a respiratory therapist must be able to observe and interact with a patient, be available to coach them, and monitor appropriate physiological parameters. Respiratory therapists must closely monitor a patient's vital signs and have immediate access to a patient requiring intervention. It is impossible to provide safe and effective treatments if the respiratory therapist is trying to concurrently treat several patients in separate rooms.

The administration of concurrent therapy on a routine basis may compromise patient safety and result in substandard care. Unless a patient is stable and has demonstrated their competency to administer their own therapy, they should never be left unsupervised while receiving a treatment. To assure appropriate and efficient care, each institution should develop its own criteria for the administration of concurrent therapy.

The AARC appreciates this opportunity to address our concerns regarding concurrent therapy and its impact on patient care. If you have any questions regarding these comments, please feel free to contact Jill Eicher, AARC's Director of Government Affairs at (703) 548-8538 or at eicher@aarc.org.

As always your input is important to the section. Please let me know of issues you would like to see discussed or researched. I can be reached via the contact information on this page. ■

The Word on the Web

In this issue, we feature "sound bites" from recent discussions on the Management Section listserv on missed aerosol medications and JCAHO site visits, continuous pulse oximetry on general medical floors, and ACLS requirements. Postings have been edited slightly for space and style considerations.

Missed aerosol medications

Manager #1: We just had JCAHO review. We were cited for not writing up delayed aerosol treatments as medication errors.

Manager #2: JCAHO . . . will hold you to whatever standard the facility policy sets for all other medications. Our policy, fortunately, didn't define or address late meds, so (JCAHO) just focused on missed meds. I had to endure a big push internally from nursing, risk management, etc., to have us fill out a missed med form for each omission. Fortunately, I was able to fend that one off. JCAHO was fine with the fact that we tracked them separately via an omission list in the department. We explained that the info eventually went to the P&T committee as med errors, but we kept it separate to keep from skewing the existing data.

Manager #3: We operate by protocols, and the docs allow us to adjust treatment times. Our policy stated at the time (of our last survey) that the therapist could adjust treatment times according to their assessment. Where I got into words with the JCAHO nurse was that my policy stated that I could adjust "therapy" times according to the RT's assessment, but it didn't say I could adjust "medication" times. We agreed that if I changed the wording to say that we could adjust "therapy and medication" times . . . then we would not receive a Type 1.

Manager #4: Our pharmacy director wrote a policy for all medications (saying that meds could be delivered up to one hour before and no later than one hour after the scheduled medication time). JCAHO was here last month. Our Missing and Late Treatment Log was fine. We always document the reason for the tardiness. Our policy is now consistent with the pharmacy. We document the med error if the treatment is missed completely.

Manager #5: We follow the same process as nursing with respect to medication errors. Our policy states that we have 30 minutes before or 30 minutes after a timed med unless it is stat. We write up anything over the 30/30 window. We have been doing this for some time now.

Continuous pulse oximetry

Manager #1: Do you use continuous pulse oximetry on general medical floors where patients are not monitored directly (as in an ICU setting)? If so, are the oximeters networked into some type of monitoring station (i.e., telemetry system), or do you rely solely on the audible alarms?

Manager #2: We do not use continuous pulse oximeters on general med/surg floors. There are some major potential liability issues associated with "monitoring" a patient and not responding to an alarm situation. The geographical layout of our hospital makes it impossible to hear the alarms at the nursing station from some patient rooms. So, as a general rule, if a patient needs a pulse ox spot check more frequently than Q4H, then they are put on continuous pulse oximetry, and if they are sick enough to need continuous pulse oximetry then they are put in a monitored bed (progressive care or ICU).

Manager #3: We have oximetry on the medical floors. It is a standard practice here. We have also experienced an increase in the need for oximetry on the floors over the past five years, as many factors are forcing us to move patients out of the ICU quicker. Patients may not need ICU or Intermediate Level Care, but still meet our medical necessity criteria for oximetry outlined in our protocols. We have not elected to remotely monitor alarms for oximeters, IV pumps, or a variety of other devices that patients are using on the general floors. Our floors are configured so alarms are audible (horseshoe arrangement of rooms with a central station open to both sides), and we keep those "higher risk" patients in closer proximity to the nursing station.

Manager #4: We use continuous pulse oximetry only on those patients whose PO_2s are labile or consistently below protocol thresholds, or on specific order of a physician. We depend on the audible alarms; no telemetry for SaO_2.

Manager #5: We use them on general ward areas for monitoring of patients receiving PCA and epidural therapy, as well as

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numerous other reasons. We do not have a central monitoring system and rely solely on the oximeter's alarms. We are starting to evaluate the Mallinckrodt In-Touch System, which will transfer signals from our new N-395 units to a pager.

Manager #6: We use continuous pulse oximetry on the general floors and rely on the audible alarms, but these patients are monitored Q1/Q2 by the nurses and floor staff. If the patient is a full code status patient and his sats are low or marginal, he is transferred to the ICU.

Manager #7: We do not use continuous oximetry on general medical floors due to the liability of alarms not being heard at that level of care. We feel if they need continuous monitoring, they should be on a monitored floor.

Manager #8: Continuous pulse oximetry is used in private rooms throughout. The nursing staff is good about helping to watch out for the patient on a sat monitor and notify us if sats drop. Most of the time the patient is already on oxygen and is receiving treatments, so we are in and out of the room five or six times per day.

Manager #9: We use pulse oximetry on patients on our general units on epidurals, and on PCA patients who meet certain criteria (OSA, excessive drowsiness, etc.). We rely on the alarms.

Manager #10: We are not networking pulse oximeters on our med-surg or step down (from ICU) units. Our discussions have involved the need to network all or none of them in order to provide the same level of care.

Manager #11: The only area outside of ICU that monitors continuously is our step-down unit — and it has telemetry. Our policy is not to use continuous oximetry on general med/surg units. We limit oximetry to spot checks Q4 hours. If the patient requires closer monitoring, he is transferred to an appropriate unit.

ACLS

Manager #1: Do you require ACLS in addition to other credentialing before allowing a therapist to work in adult critical care or the emergency room? Is ACLS a condition of continued employment?

Manager #2: We require ACLS for our core staff (RRTs), due to our integral involvement in the code team. In our policy concerning skills assessment and competency, we say that this is an item we assess upon hire and every two years. We then use the ACLS training and assessment as our competency for intubation.

Manager #3: We do not require ACLS, but will help anyone who wants to take the course to take it, and encourage them to do so.

Manager #4: This question came up at our house some time ago. We do not require our team to be ACLS certified. That is simply because, given our high degree of available human resources (residents, fellows, CCM nurses, anesthetists, etc.), there is virtually no instance where an RCP will be "running" a code. In my opinion, ACLS adds value to an RCP's job but is not something one should require of an RCP in order to be employed as an RCP. Unless one has a job description that requires the RCP to fully manage resuscitation interventions, why mandate it for employment?

Manager #5: It is required for our Adult Intubation Team, and is on our Clinical Ladder (which is voluntary).

Manager #6: Currently, we do not require ACLS but offer additional pay for ACLS training, a situation I inherited. We only have three on staff who are not current with ACLS training. Two previous hospitals where I worked did require ACLS.

Manager #7: We require ACLS. PALS and NALS are available and required in some of our hospitals.

Manager #8: Our only requirement for employment is the BLS for everyone and NRP for anyone working in the NICU. The hospital pays for these; therefore, we make them mandatory. On the other hand, because the hospital/department does not pay for the ACLS and PALS courses, they are no longer mandatory. If the RTs ran the codes, we would mandate ACLS certification and pay for it.

Manager #9: We require ACLS in order to work in our critical care areas. New hires have one year to achieve ACLS. We also require PALS for PICU and NRP for NICU. We pay for the classes and time. Since my staff have no problem with airway management, they concentrate on the meds and ECG strips. They do as well or better on these areas than nursing.

Manager #10: We do not require it upon employment, although many of our new grad hires now have both ACLS and PALS. We do require all full time staff to become ACLS and PALS certified as soon as we can schedule it. The hospital provides the course and staff are paid for training days. They are also required to maintain certification every two years, which is also provided onsite. We are upgrading our NICU and increasing our involvement, so we will be adding NRP certification this year.

Manager #11: Yes, ACLS is required at present. I pay for the class and time required to attend class. It also counts towards CEUs here. My staff and several docs have questioned the validity of having RCPs take ACLS because they don't pass the meds. I counter that we are part of the team, and as team members we need to be as knowledgeable as the other team members.

Manager #12: We have required ACLS for employment in respiratory care for 15 years. New hires have one year to obtain the credential and then it must be maintained.

If you have yet to sign up for the section listserv, visit the AARC web site (www.aarc.org), click on "Community," then "AARC Specialty Sections," then "Management Section," and follow the directions for adding your name to the list. ■

CEOs Rank Their Top Concerns

What are hospital CEOs most concerned about these days? According to a new survey from the American Hospital Association (AHA), labor and staffing are at the top of the list. The AHA poll of hospital administrators found that 72% rated those issues as one of their top three concerns in the first half of this year. That compares to just 58% in last year's poll.

The number two item on CEOs' minds is reduced reimbursement, although fewer are concerned about this issue this year than last year, 61% versus 67%. The third most pressing concern is compliance, which encompasses both HIPAA and fraud and abuse. This year, 33% ranked it in the top three concerns, up from 22% last year. ■

New JCAHO Accreditation Program

A new disease-specific care certification program is in the works at the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The program is expected to provide a comprehensive standards-based evaluation of the chronic health care services that are increasingly being offered by provider organizations, health plans, and disease management vendors. According to the JCAHO, the evaluation and resulting certification decision will be based on an assessment of compliance with standards and the effective use of clinical guidelines and outcomes measurement to manage patients with chronic conditions. ■

New and Improved?

When the Health Care Financing Administration became the Centers for Medicare and Medicaid Services (CMS) earlier this year, officials promised a friendlier organization. CMS Administrator Thomas Scully recently announced four new initiatives aimed at achieving that goal:

- CMS open-door policy committees will meet with providers and beneficiary groups on a monthly basis to discuss upcoming policies specific to their organizations and/or patient populations.
- Regional listening forums will be conducted to educate providers about recent CMS regulations.
- In-house expert teams will brainstorm ideas to make CMS less cumbersome and simplify regulations.
- The CMS telephone service, which took over 24 million calls last year, will be redesigned to increase its customer-friendliness. ■

New Staffing Standards

New staffing effectiveness standards have been approved for the Joint Commission on Accreditation of Healthcare Organization's 2002 Comprehensive Accreditation Manual for Hospitals. The standards, which are currently being pilot tested at more than 40 hospitals, are based on clinical and human resource indicators already in use at many accredited health care organizations to screen for potential staffing effectiveness issues. JCAHO-identified indicators are:

Human Resource

- Nursing care hours per patient day
- On-call or per diem use
- Overtime
- Sick time
- Staff injuries on the job
- Staff satisfaction
- Staff turnover rate
- Staff vacancy rate
- Understaffing as compared to organization's staffing plan

Clinical/Service

- Adverse drug event
- Family complaints
- Injuries to patients
- Length of stay
- Patient complaints
- Patient falls
- Pneumonia
- Postoperative infections
- Shock/cardiac arrest
- Skin breakdown
- Upper gastrointestinal bleeding
- Urinary tract infection

Organizations will be allowed to supplement this list with indicators they identify as appropriate for their organization. A minimum of four screening indicators, two from the human resource category and two from the clinical/service category, will be required, and at least one from each category must be from the JCAHO-identified list.

Organizations will be expected to monitor the application of the chosen indicators to identify patterns or trends that might merit in-depth analysis. Surveyors will then review the hospital's staffing plan, its actual staffing versus the plan, its rationale for screening indicator selection, the data collected, the results of the organization's analyses of the data, and actions taken on the basis of these analyses.

To allow hospitals time to gain knowledge and experience with the new approach, a recommendation to "cap" the standards at a "3" until January 2003 will be considered by the Accreditation Committee this fall. ■

Potential for Injury from Medical Gas Misconnections of Cryogenic Vessels

Editor's Note: *The following public health advisory was released by the Food and Drug Administration last summer. The AARC has written comments to the FDA and is awaiting response.*

Over the past four years, the Food and Drug Administration (FDA) has received reports of seven deaths and 15 injuries associated with medical gas misconnections that occurred in acute care and nursing home settings.

Nature of the problem

Oxygen supply systems in medical facilities are equipped with gas-specific connectors that fit only the corresponding connectors on the cryogenic vessels in which oxygen is delivered. In the cases we have reviewed, deaths and injuries occurred when two errors were made in sequence. First, a cryogenic vessel containing another gas was mistakenly identified as containing oxygen. Then, the gas-specific connector on this cryogenic vessel was changed or misadapted so that it could deliver the wrong gas to an oxygen-delivery system. In many of the reported incidents, the person connecting the vessel to the oxygen delivery system (either the delivery person or the facility employee) did not understand that the gas-specific connector was a safeguard designed to prevent such mishaps from occurring.

Recommendations

We urge you to take every opportunity to promote proper handling of medical gases. Inform all personnel handling and using cryogenic vessels of these recommendations. To avoid possible injuries from misconnected medical gases, we recommend the following:

- When connecting a cryogenic vessel, check the label carefully to ensure that it contains the appropriate gas for the intended application.
- Never use adapters or change the connectors or fittings on cryogenic vessels. If a connector will not connect to the oxygen supply system, the contained gas is likely not oxygen and should not be used. Contact the gas supplier for further information and guidance.
- Make sure that all personnel who will be handling medical gases are properly trained to understand the operations and connections of the medical gas system. Make sure that personnel are trained to examine and recognize medical gas labels.
- If your facility receives both medical and industrial grade gases, store them separately.

Reporting adverse events to FDA

The Safe Medical Devices Act of 1990 (SMDA) requires hospitals and other user facilities to report deaths and serious injuries associated with the use of medical devices, including devices used to deliver medical gases. We request that you follow the procedures established by your facility for such mandatory reporting.

We also encourage you to report other adverse events associated with the use of a medical gas. You can report these directly to the device or medical gas manufacturer. You can also report to MedWatch, the FDA's voluntary reporting program. You may submit reports to MedWatch one of four ways: online at http://www.accessdata.fda.gov/scripts/medwatch/, by telephone at 1-800-FDA-1088; by FAX at 1-800-FDA-0178; or by mail to MedWatch, Food and Drug Administration, HF-2, 5600 Fishers Lane, Rockville, MD 20857.

Further information regarding medical gas misconnections may be found at http://www.fda.gov/cder/guidance/4341fnl.htm. ■

Preventing VAP

Did you know the Agency for Healthcare Research and Quality (AHRQ) offers an online resource aimed at preventing ventilator-associated pneumonia (VAP)? The resource, which can be found at http://www.ahcpr.gov/clinic/ptsafety/chap17a.htm, reviews four practices with the potential to reduce the incidence of VAP in patients receiving mechanical ventilation: variation in patient positioning, continuous aspiration of subglottic secretions, selective digestive tract decontamination, and the use of sucralfate.

According to the source, VAP is a leading cause of morbidity and mortality in the intensive care unit, impacting between 6-52% of intubated patients. The cumulative incidence is approximately 1-3% per day of intubation. Overall, VAP is associated with an attributable mortality of up to 30%. Attributable mortality approaches 50% when VAP is caused by the more virulent organisms that typify late-onset VAP (occurring four or more days into mechanical ventilation).

Although specific data are lacking, the cost per episode of VAP is considered substantial. The average cost per episode of nosocomial pneumonia is estimated at $3000 to $6000, and the additional length of stay for patients who develop VAP is estimated at 13 days. ■

Employee Costs Up at Private Hospitals

According to the Bureau of Labor Statistics' Employment Cost Index, hospital employee costs at private hospitals increased 1.6% in second quarter 2001, matching the 1.6% increase in the previous quarter. These costs are 5.7% higher than a year ago.

Hospital employment costs continued to outpace compensation for all private industry, which increased 1.0% for the quarter, slowing from a 1.4% increase in the previous quarter, and 4.0% higher than a year ago.

The Employment Cost Index excludes premium pay for overtime and shift differentials. Nor does it include contract labor such as non-employee labor cost. ■

Good News/Bad News

A new Harris poll on what the public thinks about various industries resulted in some good news/bad news for hospitals. While the survey showed the public rates hospitals above other health care providers in terms of how well they serve patients, public approval of hospitals is still on the decline. Asked if they think hospitals do a good job at serving consumers, 67% of respondents said yes, a decline of 10 percentage points from 1997.

Meanwhile, 59% agreed that pharmaceutical companies do well (a 20-point decline from the previous survey), 39% said health insurance companies do a good job (a 16-point drop), and 29% said managed care companies serve consumers well (22 points less).■

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. ■

Las Vegas Hosts Next Asthma Disease Management Course

Did you know asthma is a significant key to a solid professional future in respiratory therapy? You're probably thinking, "Of course I know that, and I'm prepared for it. I'm a respiratory therapist — I know how to treat asthma." That's good news, but think again. Knowing how to treat asthma is merely a first step in preparing for your future as a respiratory therapist. The real question is, "Do you know how to manage asthma?"

Respiratory care practice is changing. Although bedside care will always be a hallmark of the respiratory therapist's role, approaches to care and levels of responsibility are changing. Protocols and assessment services are expanding the role and autonomy of the respiratory therapist. Case management and disease management are expanding the opportunities for the respiratory therapist.

The American Association for Respiratory Care knows disease management is the wave of healthcare's future. And it makes good sense — for the patient's well being and for the bottom line. What better way to approach a disease like asthma than to keep sufferers out of hospitals? Patients are healthy and feeling great and costly hospital stays become a thing of the past. That's why the AARC designed the Asthma Disease Management Course.

The popular course will be held for the last time in 2001 on November 3-4 in Las Vegas. Here is the best-packaged program on asthma disease state management specifically for respiratory therapists. Learn about what clinical issues are important in a disease management program and then what business opportunities you must consider.

The last course, held in July, was sold-out, so don't wait to send in your registration.

Make an investment in your career and take the AARC's Asthma Disease Management course. You'll receive a course certificate validating your attendance and ensuring your competence when an asthma management opportunity knocks at the door of your future. With managed care companies focusing more and more on disease management as a key to effective healthcare provision, isn't it time you learned how to manage asthma?

Don't miss this opportunity to increase your professional value and your career options by becoming an asthma management expert. ■

JCAHO Site Visit Reports

The following site visit reports were posted recently on the AARC web site:

Hospital
Glendale Adventist Medical Center
Michael McCarthy, RRT, RCP
Inspection Date: April 26, 27, 30, and May 1, 2001
What was the surveyors' focus during your last site visit?

Administrator: P.1. and equipment, biomed tags, tour of department, interaction between RT and other departments. With every inquiry he asked, "How do you know you are doing a good job?" RN Department of Health Services: preventive maintenance of equipment (records) cleanliness of areas, out-of-date medications. Physician: department operations, amount of medical direction and education, productive standards used in department, publishing good results and data.
What areas were cited as being exemplary?

Administrator: performance improvement, as well as budget process, professionalism, protocols, communication with medical director. RN Department of Health Services: current medications in bronchoscopy lab, P.M. records. Physician: department operations, supervisors, leadership, bronchodilator protocol.
What suggestions were made by the surveyors?

Administrator: need to continue to double check other departments that interface with ABG, 1 stat (clinical lab). RN Department of Health Services: new lead aprons in bronchoscopy lab. Physician: publish.
What changes have you made to improve compliance with the guidelines?

Administrator: out-of-service equipment sent completely off campus, medical director to review ABG lab policy and procedure manual yearly. RN Department of Health Services: stress compliance with manufacturers' P.M. recommendations. Physician: continue to look at operations critically.

Home Care
RG Respiratory, Inc.
Keith D. Purdy, RRT
RGRespiratory@aol.com
Inspection Date: May 21, 2001
What was the surveyors' focus during your last site visit?

IOP, verification of physician license, back up to on-cam system (i.e., if primary on call couldn't respond who would?), criminal background check on clinical staff, prevention of falsification of records — specify policy.
What areas were cited as being exemplary?

Charity/patient documentation.
What suggestions were made by the surveyors?

They suggested I use local hospital respiratory management to verify my competency since I'm currently the only clinician.
What changes have you made to improve compliance with the guidelines?

Put systems in place to verify MD/DO license on all orders/changes to orders.

Additional comments

This was my initial full survey. Final score was 94. ■

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 the 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. 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, any where.
- The largest and most impressive exhibit hall with the most vendors, where you can make you 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. ■

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

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:

_____

_____

_____

_____

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