Yesterday's Compassion, Tomorrow's Technology, Delivered Today

Second Wind

Respiratory Care News and Technology
An Award Winning Respiratory Care Newsletter

Spring, 2008

Volume 17

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Respiratory Care Administration
Angie Lutz, BS, RRT
Director

LVH-CC (610)402-8055
Andy Brown, RRT
Pediatric Coordinator
Linda Cornman, BS, RRT
Clinical Educator
Bernie Hochleitner, RRT
Clinical Coordinator
Diane Horoski,
Application Analyst
Charlotte Kranyecz,
Administrative Secretary
Bob Leshko, RRT
Clinical Information Systems Specialist
Larry Mann, RRT
Clinical Coordinator
Ken Miller, MEd, RRT
Education Coordinator
Steve Pyne, RRT
Clinical Coordinator
Wally Smith,
Technology Coordinator
Laura Williams, RRT
Clinical Coordinator

LVH-M (484) 884-2510
LVH-17 (610)402-2258
Chris Fenstermaker, RRT
Clinical Coordinator

Ancillary Diagnostics
LVH-17 (610)402-2258
Donna Barron, RRT

Respiratory Care Orientation Process Fosters Autonomy in Practice

By Jennifer Blackwell, RRT

Making the decision to change employers can be difficult. The more years spent in a position, the more difficult it becomes to leave it due to the comfort level achieved. Comfort in a job can result in stagnancy and leaving that position means leaving your comfort zone. The decision has to be made as to which is of greater priority to oneself, remaining comfortable or searching for stimulation in a new position.

Not every Respiratory Department has autonomy in their practice. Positions of little autonomy require less advanced assessment skills. Once again, this can lead to stagnancy and boredom in the profession. The decision must then be made whether to search for a position of autonomy or leave the profession. This is what led me to seek employment at Lehigh Valley Hospital and Health Network (LVHHN).

After making the decision to leave a comfortable position, my hopes were that the transition to LVHHN would move smoothly. The process was enjoyable from the very first encounter. The management personnel involved in the interview process was both personable and professional. A welcomed feeling remained throughout the lengthy interview, and an overwhelming desire to work at LVHHN resulted.

The first few days of orientation were spent in hospital orientation. Many speakers delivered hospital information in an interesting manner. A Jeopardy-like game, with working buzzers, was an unexpected and stimulating way to relay the countless aspects of LVHHN.

The first day of clinical orientation was extremely overwhelming. LVHHN is a cutting-edge hospital which practices techniques unheard of at many hospitals. Due to the patience and understanding of all management personnel and preceptors, my anxiety was relieved.

During the department orientation process, the preceptee is placed with a main preceptor, which serves to promote consistency throughout orientation. The preceptors knowledge was impressive and they went to great lengths to instill that knowledge in me. Patience was one of the greatest qualities my preceptors possessed, fostering an environment of learning and allowing me to ask any question with ease. *(Continued on Page 6)*

A LETTER FROM THE EDITOR

Kudos to Everyone

By Pamela D. Rock, BA, RRT, AE-C

Who doesn't like to be recognized and rewarded for their achievements? Everyone wants to feel appreciated. Whether it is their nature to timidly stand in the shadows or venture into the limelight, they like and want their efforts acknowledged. It is what keeps them energized, happy, caring, creative, and productive individuals and workers.

In this issue of *Second Wind* we featured the story of a new employee in our department who not only commends her preceptors for their guidance but credits them with her successful completion of the orientation process.

On pages 2 and 3, two writers take the creative plunge and successfully tug at our hearts while still feeding us new information.

Kudos are published on page 3 in each and every issue to proudly share the accomplishments of all the department personnel. We believe in publicly recognizing our team mates, and we want to encourage our new employees and graduates. Go forward and make your dreams a reality.

The remaining pages highlight the most recent advancements in our profession, technology, and department and hospital expansions.

We hope you enjoy reading our 17th publication, and look forward to our Summer and Fall 2008 issues, with the assistance of a few new talented committee members. To our contributors, thank you and keep writing!

The Perfect Marriage

Bernhart Hochleitner, RRT, AE-C

I first got married at 16.
It was the perfect marriage.
Kids at school who poked fun at me suddenly thought I was cool.
Kids who never talked to me suddenly became my best buddies.
I suddenly had so much in common with so many kids, hanging out, being cool.
I was treated with respect and had many, many friends.
It was because of my perfect marriage.

As I entered my twenties, my perfect marriage continued.
Why was my marriage so perfect you may ask?
Well, my partner never talked back to me.
We never argued.
My partner gave me so much pleasure.
My partner was always there when I needed it, without conditions.
When I was stressed, my partner was there, without conditions.
When I was nervous, my partner was there, without conditions.
When I was angry, my partner was there, without conditions.
When I was crazy mad, my partner was always there, without conditions.
When I was out drinking with friends, my partner was the perfect companion,
without conditions.

Whether in my car, during breaks at work, in the middle of the night,
even when sitting on my throne, my partner was always there, without conditions.
My perfect marriage, my partner, became a part of my being, my soul.

Through my thirties and forties my perfect marriage kept me sane.
Those late nights waiting for the kids to get home, soothed by my perfect marriage.
Those heated arguments with my husband, soothed by my perfect marriage.
Those years of financial burden and domestic unrest, soothed by my perfect marriage.
When I left my husband, and I was sad and lonely in my motel room, my perfect marriage
kept me sane and relaxed, without conditions.

Now in my sixties, my perfect marriage is no more.
As I sit here coughing and short of breath, I wonder why I remain in this
abusive marriage.
As I struggle to walk to my kitchen, I wonder how it was so easy
to leave my husband, yet so hard to leave my abusive marriage.
As I take off my oxygen, so that I can be with my partner once again,
I wonder how to get out of my abusive marriage.
But I can't. It is all I have known since the age of sixteen.
My partner and I connected, every hour of every day since those early years.
We spent more time together than I spent with my husband, kids, and friends combined.
I spent $230,000 since the start of my abusive marriage.
I relied on it during my darkest times and happiest times.
Yet I am alone, in my abusive marriage.

Now in my seventies, and a merciless invader spreading to every part of my body,
cancer has now become part of my being, my soul.
I finally found a way to get out of my abusive marriage.
I don't know how; maybe because I have very little breath left in me,
maybe because I am penniless. But I have finally done it.
I have divorced my cigarettes, my faithful Marlboros, but a little too late.
Now I suffer alone, in pain and in agony, and I will die alone.
All because of my perfect marriage.

RC News

Welcome New Employees !

Jennifer Blackwell, RRT
Thomas Bridges, RRT
Shelly DeBor, CRT
Lenny DeFranco, RRT
Jeanna Marie Gaye, RRT
Robert Jordan, RRT
Chris Menichella, CRT
Hayfa Shakkour-Perez, RRT
Tracey Sabol, CRT
Danielle Simcox, CRT
Tara Stephens, CRT
Sandye Vicevich, RRT
Laura Wassiluk, RRT
Kelly Zehnder, CRT

Respiratory Therapists Needed!
Varied Shifts
Allentown, PA

RRT credentialing or registry-eligible within 18 months; BLS, ACLS, and PALS preferred.

• Relocation assistance
• Immediate, fully paid medical benefits
• Tuition reimbursement

To apply, please visit www.lvh.org and click on Careers/Job Search/ Allied Health, or e-mail: Jaime.Rebner@lvh.com. EOE

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Kudos— We are Magnet!

Congratulations to the Respiratory Clinical Specialist Team
for having received the
Pam Laffin Award,
from the Lehigh Valley Coalition
for a Smoke Free Valley,
for their accomplishments
in the LVHHN
Smoking Cessation Campaign.
Pam Laffin was a 35 year old former smoker, who prior to her death from COPD, dedicated her last days to educating the community on the debilitating effects of tobacco use.

Congratulations !

Pamela Rock, BA, RRT, AE-C
for passing her
Asthma Educator Certification Exam

William Weber, RRT
for passing his
Registered Respiratory Therapist Exam

Adopt—A—Family

Many thanks to the Respiratory Care Department staff and contributors for their overwhelming generosity!

Thank you Marsha Becker, RRT, AE-C and Diane Horoski for facilitating a record-breaking 2007 Christmas gift-giving campaign!

The Longest Word?

By Janet Navin, RRT, CPFT

One evening my daughter was busy chatting with friends on the internet, when she called out, “Mom, What does pneu-mo-…”
She continued to stumble through the syllables.
I interrupted, “You mean pneumoconiosis?”
She replied, “It’s something like that but a whole lot longer.”

One of her on-line friends had been given a school assignment to find the longest word in the English language and also provide a definition. The word was *Pneumonoultramicroscopicsilicovolcanoconiosis (-koniosis).*

My daughter asked, “Do you know what it means?”
I replied that pneumoconiosis is a lung disease caused by inhaling dust, and I suspected that it was a specific type of dust, probably volcanic ash.

The definition is: the forty-five-letter word is the name of a special form of silicosis caused by ultra-microscopic particles of silica volcanic dust. The word was coined by Everett M. Smith in 1935.

It is currently believed that the word was created for the sole purpose of showing that medical syllables can be tied together to make very long words, or medical “word inflation”.

Pulmonary Function Testing Requires Good Communication Skills

By Ellie Peluso, RRT-NPS, RPFT, AE-C

Good communication skills are your most effective tool in performing a quality pulmonary function test. The pulmonary function testing procedure is effort dependent and requires patient cooperation. The validity of test results is directly related to the patient's ability to understand and follow direction. Frequently, a poorly performed test is due to the technician's inability to effectively communicate with the patient. Here are some communication guidelines that will help you obtain accurate and reproducible data:

- Introduce yourself to the patient. The patient will be a little anxious and nervous upon their arrival to the PFT lab. A friendly greeting will help them to relax and feel comfortable. Patient preparation is the initial step in the PFT communication process.
- Introduce the PFT equipment and address any concerns they may have regarding the body box. Claustrophobia is a common concern; you may need to discuss an alternative method for lung volume measurements.
- Review and discuss the physician's order.
- Explain the testing procedure and allow the patient to ask questions.
- The actual test performance requires additional skills and communication techniques. When coaching the patient through a procedure, the technician should use verbal and visual encouragement. There is no such thing as sensory overload when coaching a patient through pulmonary function testing.
- Always remember that each patient is a unique individual. We all process information differently. Adapt your approach to meet your patient's needs. Occasionally, the patient will need additional communicative resources, such as an interpreter service to aide in any language barriers that may interfere with the testing procedure.
- Sometimes the patient just needs a little support and reassurance from family. So invite a family member into the pulmonary function lab to observe and provide additional encouragement.

Introducing the New Oxy-Tote O2 Transport Cylinder

By Wally Smith, Technology Coordinator

The Pressure Gauge displays the cylinder contents regardless if the cylinder valve is "Closed" or "Open".

Be sure the cylinder valve is turned "Open" by rotating it fully counter clockwise.
This valve should never be in the "Closed" position.

Flowmeter points of interest:

1. "AUX" stands for auxiliary. In this position, the flowmeter is "Off" and pressure is available to the auxiliary outlet on the left hand side.

2. Before attaching the patient to the connector on the right hand side, turn to the desired flow setting. Listen for the flow to activate for five (5) seconds, then connect the tubing. If you do not hear the flow, make sure the cylinder valve is turned on fully counter clockwise.

Each Oxy-Tote has a flow duration reference chart.

Intelligent Ventilation

Bernhart Hochleitner, RRT, AE-C

Last spring I was afforded the opportunity to travel to Reno, Nevada to attend a workshop on *Intelligent Ventilation*, sponsored by Hamilton Medical and held at the opulent Sienna Hotel/Spa and Casino. I chose to opt out of the avocado facial and sea grass pedicure offered at the Sienna Spa, and instead chose to spend my free time photographing beautiful Reno. The rest of my time was spent at various workshops related to the Galileo ventilator and Adaptive Support Ventilation (ASV).

Do No Harm. It is a fundamental principle for health care providers. Despite the extraordinary hard work and best intentions of caregivers, thousands of patients are harmed in US hospitals every day. The Institute of Healthcare Improvement's 5 million lives campaign aims to reduce the nearly 15 million instances of medical harm, which occur in the U.S. each year[1]. The *Intelligent Ventilation* workshop utilized this theme in presenting ASV as a closed-looped ventilatory tool that has the potential to reduce mortality secondary to medical errors.

Manipulation of ventilator settings by respiratory therapists are minimized in ASV which decreases the likelihood of "dialing in" the wrong settings. Also, the dynamic nature of lung mechanics and the deleterious changes that can occur within the airways may initially be undetectable to the respiratory therapist. Thus the delicate "tweaking" of ventilator parameters needed to address these subtle changes may not occur until after critical ventilator alarms are triggered and injurious events to the lung parenchyma become widespread. Once alarms are activated, there may be a delay in therapist intervention depending on his/her current workload demands and other patient encounters. ASV continually monitors and detects changing pulmonary mechanics and selects those ventilatory strategies conducive to minimizing the likelihood of Ventilator Induced Lung Injury (VILI). ASV delivers "real-time" ventilatory management and "tweaking" on a breath-by-breath basis.

The Galileo ventilator also offers a tool to optimize Positive End-Expiratory Pressure (PEEP). The P/V tool is a welcome addition to the respiratory therapists arsenal of assessment tools. As with ASV, the P/V tool optimizes patient safety by providing the respiratory therapist with the optimal PEEP level for that particular patient. Hence, under-recruitment or over-recruitment of alveoli is avoided and the likelihood of VILI is minimized. The Galileo P/V tool is an objective measurement, free of operator bias. It provides repeatable and quantifiable patient data allowing for the optimization of ventilation settings with maximum lung protection[2]. The P/V tool and ASV are relative newcomers to the world of mechanical ventilation.

We should feel proud that we are on the front lines in introducing new ventilatory modalities, such as ASV, to our collaborative clinical teams. As respiratory therapists, we must continue to embrace and evaluate new technology that falls on our doorstep. We must put aside our fears of the unknown, embrace change as an ally for our profession, and recognize our position as national leaders in the delivery of respiratory care.

[1] "Protecting 5 million lives from harm." A resource from the National Institute for Healthcare Improvement. Retrieved July 5th, 2007. http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm?TabId=1

[2] ã 2006 Hamilton Medical AG product guide.

Palliative Care From a Different Perspective

By Cynthia Anderson, RRT

In an interview on November 2007, Respiratory Therapist, Kristin Cumano, shared her experience of Palliative Care on the receiving end. Her husband, Anthony, was diagnosed with esophageal cancer on January 13, 2006. It was a shock to Kristin, her husband, and family. Everyday life changed drastically for the Cumano's.

Anthony spent time in the Intensive Care Unit (ICU) following surgery, and he was also on the Oncology Medical/Surgical floor. Kristin felt that the staff of Lehigh Valley Hospital - Muhlenberg gave him the best of care. Their dedication was a tremendous comfort. She had a lot of questions and the staff took the time to listen and build a relationship. For example, it was very helpful when the nurses gave Kristin additional information concerning the side effects of different types of chemotherapy medications.

Dr. Daniel Ray spoke about Palliative Care at the *Lehigh Valley Hospital Concepts in Respiratory Care Fall Symposium,* September 2007. Dr. Ray explained that Palliative Care is important for all ICU patients. Communication between the patient, the family, and the health care team are essential. The patient and family should be recognized as one unit, and the health care team should elicit patient values and preferences. They should also seek to recognize the patient and family communication style, and involve them in decision-making. Dr. Ray explained that the patient and family needs to be educated about the plan of care, treatment options, and goals of the patient's care. Kristin shared, "It helped when the staff really took the time to listen to us."

Anthony and Kristin never gave up hope until the day the doctor explained Anthony's prognosis. The transition from aggressive cancer treatment, to palliative care, and then end of life care was a tremendous change for the Cumano family. Kristin will never forget that day. Kristin and Anthony needed each other and the support of other people. Kristin spent hours holding Anthony's hand. The staff, and even from some of her co-workers, demonstrated the compassion and support that Kristin really needed.

Anthony passed away on October 25, 2006. Kristin feels that her experience has had an impact on her own practice of Respiratory Care. Kristin said, "I have a lot more compassion for each person, and I take the time to listen to what each person is saying."

(Continued from Front Page)

The orientation Educator and all Clinical Coordinators were also extremely busy but questions and concerns were always welcomed. Feedback from both the preceptors and me was used to continually monitor areas for improvement. Weekly meetings with the orientation educator served to deliver all the knowledge that was necessary for me to become a staff therapist. Goals for the next week helped to guide the preceptor and me to continually learn the information needed to be an effective therapist.

During my orientation, a balance of monitoring and freedom to learn was maintained. The preceptors organizational skills were phenomenal. They enabled me to learn by doing but were continually present for questions. As orientation progressed, more freedom and responsibility was passed to me. This process was tailored to my experience and comfort level. When I was able to perform all duties independently and felt comfortable doing so, my orientation was complete.

Team Spirit

Respiratory ROC

By Angela Lutz, BS, RRT-NPS, AE-C

As a Director at Lehigh Valley Hospital and Health Network (LVHHN), I can say there are many things to occupy my mind. As a result, I tend to forget an occasional detail. But, there is one detail I have no problem remembering…the opening of the Kasych Pavilion. Every morning driving into work, the additional large building on campus has a unique way of reminding me that we are expanding!

So what does this mean for the Respiratory Care Department? Yes, more patients. That's obvious. What else you say? Much more! I have had the pleasure of attending the LVHHN at Cedar Crest-ROC meetings to participate in and keep abreast of all the advancements and preparations. Being a department that participates in almost all aspects of patient care, we had a unique role in this transition.

The expansion involved the addition of both critical care and medical/surgical units. Our education team conducted tours and orientated our staff. Linda Cornman, Clinical Educator, graciously adopted this task with the assistance and guidance of Sue Steward, Director of Special Projects. Linda completed the process of molding the orientation format from Sue, and arranged the tours.

In the medical/surgical areas, our Clinical Specialists have expanded their services to these new units, a couple of which include Smoking Cessation and therapeutic consultations. The specialists have moved into a brand new office on the third floor, and yes, it has a window!

On the critical care end of things, the Burn Unit and MICU/SICU (with the newly combined ICU West) have been relocated to Kasych. In preparation, we needed to have our Clinical Information Systems Specialist, Robert Leshko, validate that all the Metavision interfaces were functioning for connection to our ventilators. Our equipment team, led by Wally Smith, Coordinator of Respiratory Technology, has facilitated the arrangement of supplies and storage for our equipment on each unit along with the Unit Directors.

Finally, during the actual transition itself, our staff was actively involved in helping with the transfer of patients requiring respiratory assistance, such as the ventilated patients. We needed to coordinate care at the 'original units', with the transfer team, and the 'receiving units'. All hands were on board! The move into the new tower was done safely and collaboratively by *the best* respiratory and nursing care teams!

Respiratory Care Department Shines at the National Conference

By Kenneth Miller, MEd, RRT-NPS, AE-C

Once again, the Lehigh Valley Hospital and Health Network (LVHHN) Respiratory Care Department had a significant impact at the American Association of Respiratory Care National Conference. Two oral presentations were given; *Airway Pressure Release Ventilation* was presented by Ken Miller, MEd, RRT-NPS, AE-C and Jim Gates, RRT presented on the *Weaning of Post-Operative Patients via MMV*. Oral poster presentations were presented by Robert Leshko RRT, Mike Marrone RRT, and me. Dave Rubish, RRT was a member of the winning Sputum Bowl Team from Pennsylvania. The Sputum Bowl is a competitive quiz game that challenges members from each state to be the quickest to answer clinical questions correctly.

Approximately six thousand other Respiratory Care Practitioners were in attendance representing over four hundred hospitals and all fifty states. Also included in the conference were two hundred lectures and three hundred poster presentations. This was the eighth consecutive year that the LVHHN Respiratory Care Department has presented at the national conference. Highlights from this year's conference included; how to manage a department effectively, finding evidence based literature to support therapeutic procedures, mechanical ventilation strategies in all different patient populations and age groups. Each morning started out with a keynote speaker then proceeded into many smaller lectures, and included a vendor area that consisted of over four hundred manufactures and suppliers of respiratory care equipment. Breakfast workshops were offered for even more learning. Jim Gates and I participated in a three mile run with Jim finishing in tenth place. Dinners and parties made the conference even more exciting.

The Respiratory Care Department is currently gearing up it's research to once again disseminate important clinical results to fellow practitioners at next year's conference that will be held in Anaheim, California.

Special thanks to our Contributors, from your *Second Wind* Committee:

Diane Horoski, Charlotte Kranyecz, Michele Maciejewski, Kenneth Miller, Chair, Eleanor Peluso, John Reed, Pamela Rock, Editor, Wally Smith, Joel Strohecker, and Willie Williams.

Second Wind welcomes letters to the editor and articles on topics pertinent to the profession of Respiratory Care. Letters must be under 200 words, signed by the author and mailed. Articles must be under 500 words and GUI e-mailed with a contact address and telephone number. Photographic services are available or hard copy photos can be submitted with your article.

For more information contact **Pamela.Rock@lvh.com**

Visit our Respiratory Care Web site on the LVHHN Intra net!

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