

# Respiratory Update

Spring 2005



Larry L. Renner, BS, RRT, RPFT, RCP  
President

## Larry L. Renner Elected President

The Respiratory Care Board (Board) unanimously elected Larry L. Renner to serve as President, effective January 1, 2005. Since his appointment in 2001, Mr. Renner has served the Board in various capacities, most notably as Vice President and as Chair of the Professional Licensing Committee (PLC).

With his leadership, the PLC has worked diligently to address the potential need for regulation of several unregulated practices that are emerging and that have profound effects on the consumers of California, specifically, the practices of polysomnography, pulmonary function testing and hyperbaric oxygen therapy. Mr. Renner is also leading the PLC as it finalizes its report, which outlines various concerns related to respiratory care services being provided in home care settings and which will include proposed solutions for consideration.

As Chair of the PLC, Mr. Renner is also responsible for responding to scope of practice inquiries on behalf of the Board. Preparation of these responses often requires a considerable amount of time and extensive research, however, Mr. Renner's experience and expertise allows him to effectively address and respond to

these various inquiries. These tireless and dedicated efforts show his unyielding commitment to the Board's mandate and mission.

Another example of his contribution to the profession, is his recent development of a DVD presentation entitled, "Respiratory Care in California" which provides information about the history of the profession, career opportunities and the role of the Board. Mr. Renner initiated the project with past President Dr. Barry Winn and was responsible for all aspects of development. Through such actions, Mr. Renner demonstrates his personal dedication to the respiratory care profession and the consumers it serves.

## Governor Calls for Further Review of Reorganization Plan, Reforming California's Boards and Commissions

On February 17, 2005, Governor Schwarzenegger withdrew his plan to eliminate some 88 boards and commissions.

The *Governor's Reorganization Plan, Boards and Commissions*, was designed to enhance the accountability, efficiency, and responsiveness of State government and named the Respiratory Care Board (RCB), among 88 boards and commissions, for elimination. The Plan would have transferred the RCB's existing regulatory "program functions" to the Department of Consumer Affairs to provide oversight and establish policy and was intended to go into effect in less than 6 months, barring objection from the Legislature. Under this process, reorganization plans are "all or nothing" and cannot be amended.

The Plan was initially submitted to the Little Hoover Commission (Commission) on January 6, 2005. The Commission is charged with assessing reorganization plans to assist policy-makers in "promoting economy, efficiency and improved service in the transaction of the public business." In addition to welcoming written comments, the Commission held hearings on January 26th and 28th in Sacramento, to provide a forum for affected agencies, constituencies and interest groups to comment on the Plan. During the hearings, the Commission expressed concern with the Plan's inclusion of eliminating health boards which had previously been recommended for retention by the California Performance Review and Little Hoover Commissions.

The Commission was expected to complete its "advisory" report by March 6th for review by the Governor and the Legislature. However, on February 17th the Governor withdrew the Plan citing the proposal "will benefit from further review." The Governor indicated that he has had some good discussions regarding the plan with legislators, and wants to perfect and improve parts of the proposal. According to the Sacramento Bee, the Governor didn't rule out trying to move forward with parts of the plan through legislation which would include some of the items that legislators favored.

### License Verification Available Online!

You can verify licensure status online via the Board's website at [www.rcb.ca.gov](http://www.rcb.ca.gov).  
The online license verification system is available 24 hours a day,  
7 days a week and records are updated daily (M-F).

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## Respiratory Care Board of California

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## President's Message

My election as the Respiratory Care Board (Board) President was followed very quickly by a shock from Governor Schwarzenegger's office issuing a proposal to eliminate 88 boards within California, including the Respiratory Care Board. After carefully reviewing the proposal and speaking with many other colleagues across California, it was clear to me that the proposal was too aggressive and left many unanswered questions regarding the safety of the California consumer. Based upon that conclusion, I began writing letters to the Little Hoover Commission (Commission) and both California Senators and Assembly Members asking for their support in rejecting the proposal. I think the California budget crisis is clearly understood and felt by all of us. However, this crisis will not be resolved by eliminating these boards whose primary function is public safety and where the majority of the board appointees accept their appointments as volunteers for the State.

On January 26<sup>th</sup> and 28<sup>th</sup> open hearings were held by the Commission in Sacramento, to discuss the proposal with the public. The Commission is charged with evaluating reorganization plans to determine whether or not a plan promotes economy, efficiency and improved service in the transaction of public business. Normally, the Commission then submits a report to the Governor and the Legislature recommending whether or not the plan should go into effect. It is my opinion that the Commission heard the concerns of both professionals, as well as consumers, and would have communicated to the Governor and the Legislature its recommendation to reject the proposal to prevent the elimination of these boards. Fortunately, Governor Schwarzenegger recognized the concerns raised during the hearings and notified the Commission that the proposal would benefit from further review, removing the current threat of elimination.

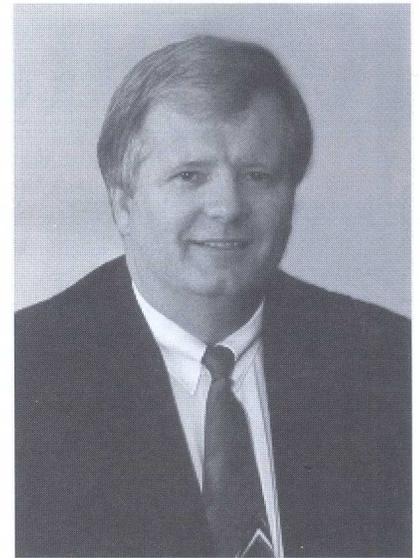
Despite the uncertainties, it has been my opinion that the Board needs to continue its work diligently and without interruption or distraction. It has therefore, been my direction that all the committee work previously under way be continued as planned.

As the newly elected President of the Board, it will be my honor to serve this profession and its consumers to the best of my ability. This task is less burdensome because of the depth of the professionals who currently make up the Respiratory Care Board. The Board's composition bears tremendous public, as well as professional, tenure and experience. It has demonstrated its ability to develop an effective strategic plan (including recommendations from the Joint Legislative Sunset Review Committee) and execute it in a timely and efficient manner. It has also demonstrated its ability to engage the issues of ethics, clinical practice and the pursuit of new legislation aimed at improving the profession and the safety of the California consumers we are charged to protect.

The challenges that face this Board are many and require continued and focused effort to achieve the desired results. These challenges include continuing our work regarding pulmonary function testing, home care, sleep testing and hyperbaric oxygen therapy. Our collaborative work with many professional groups has proven to be very productive in our effort to sponsor appropriate legislation, to improve patient safety and outline minimum educational and/or licensure requirements for these services. These challenges will also require collaborative marketing efforts to continue producing well-educated and well-qualified respiratory care professionals to meet the increasing need for practitioners within the State. We must also establish and/or strengthen collaborative relationships with professional organizations to improve patient safety and patient care delivery. But most of all, we must continue our accountability to the fiscal demands entrusted to us, by the respiratory practitioners and the consumers of California.

To achieve these results will take more than members of a board working to accomplish these challenges. It will also take a profession with the willingness and fortitude to hold our fellow practitioners to a higher ethical and professional standard. For this to occur, I challenge each practitioner in California to get more involved in the profession in whatever way seems appropriate for your personal situation. At a minimum, I believe every practitioner should increase their active participation in both their state and national professional organizations. I would also challenge more practitioners to attend the State Respiratory Care Board meetings. Challenge yourself to find out what the Board is all about and the effect it brings to the profession.

I welcome the challenges this year will bring us. It is from these challenges that change will emerge and strengthen the profession and consumer protection. For it was once said, "Change is the law of life. And those who look only to the past or present are certain to miss the future" (*John Fitzgerald Kennedy*). Let us strive to be the future of healthcare by ensuring our practice achieves the highest standards of patient care, ethics, and patient safety.



Larry L. Renner, BS, RRT, RPFT, RCP  
President

## Parents Express Appreciation to Respiratory Care Practitioner Julie Hubbard-Morsy

The Respiratory Care Board (Board) received a copy of the following letter from the parents of a pediatric patient recently treated by licensed respiratory care practitioner Julie Hubbard-Morsy.



Julie Hubbard-Morsy, RCP

As acknowledged by the infant's parents, Ms.

Hubbard-Morsy extended an extra measure of care to their son during his recent treatment at the facility where she is employed.

The letter is a reminder of how important respiratory therapists are, not only to their patients, but to their family members, as well.

The Board recognizes that all too often dedicated therapists go unnoticed and welcomed this opportunity not only to acknowledge and thank Ms. Hubbard-Morsy for her compassion and commitment, but to also express its appreciation to all California respiratory care practitioners for their continuous dedication to patient care.



Mercy Methodist Hospital  
Respiratory Care Practitioner's Unit  
7500 Hospital Drive  
Sacramento, CA 95823

To whom it may concern:

I would like to make the director or supervisor that oversees the respiratory care practitioners at Methodist Hospital aware of our appreciation for their employee Julie Hubbard. On February 12, 2005 Julie Hubbard went above and beyond what she was required to. Julie Hubbard was supposed to be off the clock at 8p.m., but she ended up staying with us until past 11p.m. Julie came to say goodnight and saw that I was tired and upset with my son's condition. We had been moved to a 2<sup>nd</sup> room where my son Rudy was not hooked up to monitors. I told Julie that my son was so tired and had no energy. Julie asked to take a look at my son, Rudy, before she left. At that point Julie asked that we call a nurse and another RCP to assess my son's condition. My son was transferred to another room, put on oxygen and an IV. A lot of other procedures and tests were run on my son. Julie was concerned for my son because his stomach was retracting so deeply and he was becoming more tired as he worked to breathe. I truly believe that Julie's involvement with my son that night helped turn his situation around. I don't know many people that would stay three hours past their work schedule and be so involved with their patient. Again we would like to make Julie Hubbard and Methodist Hospital aware of how much we appreciate Julie helping our son.

Thank you,  
Rudy Chavez & Clarisa Serrato

## Law and Professional Ethics Course

The Board is moving forward with establishing regulations to implement a Law and Professional Ethics Course requirement. As proposed, the course will be required prior to initial licensure, during every other renewal cycle, and prior to reinstatement of a revoked license.

This is not a reflection upon the personal ethics of RCPs by any means, or a course to *teach* anyone ethics, but rather a course designed to inform current and new RCPs of the expectations put upon them as professional practitioners in the State of California.

In California, RCPs are considered professionals, and because of that status they are held to a higher standard than those in other non-professional positions. Professionals are expected to obey not only the laws that apply to their profession, but those that apply to the public as a whole, and to also act at all times with a high level of *professional standards, aka ethics*. For professionals, this applies both inside and outside the workplace.

Many RCPs in California are not aware that their activities outside the workplace can potentially put their license to practice in jeopardy. Also, many RCPs are not fully aware of the limitations and full expectations of the Respiratory Care Practice Act and how it affects what they do, or do not do, while at work. So, in essence, the purpose of this course is to make sure that all RCPs are fully aware of all the expectations put upon them as professional, licensed practitioners in California. The old adage is, "*An ounce of prevention is worth a pound of cure.*"

The new course requirement is tentatively scheduled to go into effect January 1, 2006.

### 2005 BOARD MEETINGS

The Respiratory Care Board of California's remaining meetings for 2005 are tentatively scheduled as follows:

**Board Meeting &  
Strategic Planning Session  
Thursday & Friday  
August 11-12, 2005  
Sacramento**

All meetings (including the Strategic Planning Session) are open to the public. The Board welcomes and encourages your attendance!

Please visit our website at [www.rcb.ca.gov](http://www.rcb.ca.gov) for more information on meeting dates, times and locations. Agendas for upcoming meetings are posted 10 days prior to meeting dates.

### Respiratory Care Board Mandate

*The Respiratory Care Board of California's mandate is to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care. Protection of the public shall be the highest priority for the Respiratory Care Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.*

## Legislation Update

The following legislation became effective January 1, 2005:

Senate Bill 1912 (Ashburn) - Authorizes a pupil to carry and self-administer inhaled asthma or auto-injectable epinephrine medication if the school district receives a written statement from the physician detailing the method, amount, and time schedules by which the medication is to be taken and a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

Senate Bill 1913 (Figueroa) - Clarifies the scope of practice as it relates to ventilatory support and grants the Board the authority to establish an in-house process to stipulate to a public reprimand for some disciplinary matters affecting licensees.

Assembly Bill 2132 (Reyes & Chan) - Authorizes a pupil to self-administer asthma medication in any area of the school grounds, and during any school-related activity, if the parent or guardian of that pupil provides written consent to the self-administration, and certification that the pupil both suffers from asthma and is able to self-administer medication. This legislation also requires the school in which the pupil is enrolled to keep information regarding the asthma medication on record.

Assembly Bill 2185 (Frommer) - Requires a health care service plan that covers outpatient prescriptions drug benefits to provide coverage for inhaler spacers, nebulizers, and peak flow meters when medically necessary for the management and treatment of pediatric asthma and to provide coverage for pediatric asthma outpatient self-management training and education.

Assembly Bill 2436 (Bates) - Under existing law, only designated health care personnel are authorized to perform, under specified conditions, clinical laboratory tests or examinations that are classified as waived, moderate complexity, or high complexity under federal law. This legislation authorizes a person performing a non-diagnostic general health assessment to also perform, under specified conditions, a clinical laboratory test or examination that is classified as "waived."

For the complete text or more information on these and other bills visit: [www.leginfo.ca.gov](http://www.leginfo.ca.gov).

## Medicare Home Health Services Benefit

Continuing to follow the American Association for Respiratory Care's lead, the Respiratory Care Board (Board) issued another letter to all California congressional members in December urging for legislation that will recognize respiratory therapists under the Medicare home health services benefit. It has been shown that the use of RCPs to treat respiratory diseases results in controlled costs and higher quality of care. The Board is optimistic that its efforts will not go unheeded and that, ultimately, California's consumers with respiratory ailments will greatly benefit.

## New Registered Respiratory Therapist (RRT) Admission Policy

Effective January 1, 2005, the National Board for Respiratory Care (NBRC) changed its admission policy for the RRT examination to place a three-year limit on the length of time an individual may remain eligible for the exam. Therefore, new graduates of accredited advanced level programs now have three years from their date of graduation to complete the RRT examination. Those individuals currently in the examination process, either having already graduated, already holding the CRT credential or having passed one part of the RRT Examination, will have three years from January 1, 2005 to achieve the RRT credential or will be subject to retaking and passing the CRT examination for re-credentialing to have their eligibility for the RRT reinstated.

In an area related to the three year eligibility limit, the Respiratory Care Board (Board) reviewed data concerning the number of California licensees who also possess CRT and/or RRT credentials at its December meeting. It found:

30% of licensed RCPs hold the RRT (and CRT) credential  
46% hold the CRT credential only  
24% hold no CRT/RRT credential

The Board will continue to monitor and report credentialing data to determine if there is an increase in the number of licensees earning RRT credentials, as a result of NBRC's new requirement to take and pass the registry exam within 3 years of earning the entry level CRT credential.

Please note that the CRT and/or RRT credentials are not required for licensure in the State of California.

## Ethical Guidelines

The Board continues to recognize and support the American Association for Respiratory Care's Statement of Ethics and Professional Conduct for the purpose of promoting professionalism.

American Association for Respiratory Care  
Statement of Ethics and Professional Conduct

In the conduct of professional activities the Respiratory Therapist shall be bound by the following ethical and professional principles. Respiratory therapists shall:

- Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals.
- Actively maintain and continually improve their professional competence, and represent it accurately.
- Perform only those procedures or functions in which they are individually competent and which are within the scope of accepted and responsible practice.
- Respect and protect the legal and personal rights of patients they care for, including the right to informed consent and refusal of treatment.
- Divulge no confidential information regarding any patient or family unless disclosure is required for responsible performance of duty, or required by law.
- Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.
- Promote disease prevention and wellness.
- Refuse to participate in illegal or unethical acts, and refuse to conceal illegal, unethical or incompetent acts of others.
- Follow sound scientific procedures and ethical principles in research.
- Comply with state or federal laws which govern and relate to their practice.
- Avoid any form of conduct that creates a conflict of interest, and shall follow the principles of ethical business behavior.
- Promote health care delivery through improvement of the access, efficacy, and cost of patient care.
- Refrain from indiscriminate and unnecessary use of resources.

## Respiratory Care Recruitment Strategies: What Works and What Doesn't?

Excerpts from the following article have been reprinted with the permission of the American Association for Respiratory Care, which first published the entire article written by Terry S. LeGrand, PhD, RRT, FAARC and David C. Shelledy, PhD, RRT in the Respiratory Care Education Annual, Fall 2004. Please contact the AARC for more information.

Job opportunities for respiratory therapists are expected to be excellent over the next decade due to increasing numbers of patients suffering from cardiopulmonary diseases such as pneumonia, emphysema, chronic bronchitis, and asthma. The Bureau of Labor Statistics predicts a 35 percent increase in demand for respiratory therapists through 2012, making respiratory care one of the fastest growing professions. According to 2001 CoARC data, however, in the past 10 years there has been a decline in enrollments in respiratory therapy educational programs. This situation sets the stage for a potentially critical shortage of qualified respiratory therapists in the face of predicted increases in the demand for respiratory care services.

At our University, we employ a number of recruitment strategies designed to attract applicants to our program. These strategies include direct mail, participation in college and high school career fairs, placement of ads in college and university newspapers, and public service radio announcements. We also maintain a web site that is designed to provide the prospective student with information about respiratory therapy as a career choice and how to go about applying to the respiratory care program. These recruitment strategies are expensive, and in this time of diminishing resources, it is important to determine the most successful, and yet cost-effective, strategies for attracting new students. The purpose of this study was to determine the most effective strategies for recruiting applicants to our respiratory care baccalaureate degree education program.

In this day of electronic technology, one would expect the Internet to be the number one source of information about career options for today's college student. The most common source of information for applicants to our education program, however, was the multiple direct mailings we do each year. At least three times per year, we mail packets containing brochures and letters to science majors and pre-health career students whose names appear on mailing lists obtained from all area colleges and universities. Our recruitment letter markets the profession, and is accompanied by an invitation to an open house for interested students. Our brochure also includes career information, as well as a description of the program and admissions requirements.

Printing brochures and letters and mailing packets are significant expenses for our department, and we do this mailing three, and occasionally four times each year. Recently, we began asking applicants to identify which of the multiple mailings convinced them to apply to our program, and almost invariably, the answer is the second or third mailing. According to our applicants, they typically discard the first one, but by the time the second or third letter and brochure arrive in the mail, they begin to regard our persistence as a sign that respiratory care is their best career choice.

Because of the high cost of direct mailing, it may be necessary to investigate alternate funding sources. One source of funding may be the hospitals that employ graduates of respiratory therapy programs. It may be possible to solicit funds for student recruitment from hospitals and other health care agencies, if administrators recognize its value as an employee recruitment strategy.

According to our applicant form, the second most important source of information about the program was friends or family members. A survey of 253 respiratory care education program directors found that the recruitment method most commonly listed was "word of mouth." This is consistent with our current findings and reinforces the need to present the profession in a positive way. While "word of mouth" as a source of information about respiratory care as a profession is difficult to control, all practitioners should be aware of its importance in promoting our profession as a positive career option.

Use of the Internet to market educational programs is much less expensive than direct mail, but it will be effective only if potential applicants actually visit the web site. The most likely reason that our Internet web site was cited as a source of information only 16 percent of the time may be that potential students are not familiar with the profession of respiratory care as a career choice. It is up to educators and practitioners to promote the profession of respiratory care so that word gets out that our educational programs provide students with an exciting and rewarding career choice.

Ongoing recruitment activities are necessary to ensure an adequate student applicant pool for schools, as well as adequate human resources for the profession. Due to the scarcity of financial resources, it is important that the best and most cost-effective strategies for attracting new respiratory therapy students be employed. This study revealed that almost half of the applicants to our Respiratory Care program result from multiple direct mailings that we undertake each year. Recommendations by friends and family members, the program web site and college career fairs were also effective in attracting students. Marketing the profession using recruitment materials distributed by direct mail to prospective students, use of web sites and college fairs, and letting others know who respiratory therapists are and what they do, may be our best strategies for putting fresh, new faces at the bedsides of our future patients.

*"It is up to educators and practitioners to promote the profession of respiratory care so that word gets out that our educational programs provide students with an exciting and rewarding career choice."*

## Can a Dishonored Check Affect My License Status?

Many licensees are unaware that when a renewal payment is returned due to insufficient funds, it is as if no payment was ever received, thus the license is not renewed and becomes invalid prohibiting that person from practicing respiratory care anytime following the license expiration date. In most cases, it is not immediately evident that a payment is dishonored. As such, a renewal license may be issued. However, once the Board is made aware that the payment has been dishonored, any license previously issued becomes invalid. If this is not resolved prior to the license expiration date, the renewal is subject to a \$230 delinquent fee. In addition, if a person continues to practice respiratory care without a valid license, the person may be subject to a citation and fine up to \$50 per day of unlicensed practice.

To avoid additional fees and the possibility of a citation and fine, licensees should always renew as early as possible and ensure proper funds are available within their accounts to cover checks written. If an unforeseen circumstance occurs and funds are not available to cover the check, the practitioner should immediately contact the Board to rectify the situation.

### Satisfaction Survey

We want your feedback.

Please visit our website at:

[www.rcb.ca.gov](http://www.rcb.ca.gov)

and complete

our on-line

Satisfaction Survey.

## Scope of Practice Inquiries & Responses

**Inquiry:** Could you tell me the appropriate thing to do when no one comes in on the night shift following me after working a twelve hour day shift? Further, what are my legal obligations and liabilities regarding my ability to properly and legally leave my patient workload with the nursing supervisor or some other licensed staff member arriving on night shift?

**Response:** The Board is concerned about the issue you sent to us indicating that you are not certain what action you would take when you have a staffing issue at your facility. Usually, these matters are dictated by hospital policy and are very clear about who is called and how the patients receive treatment. The Board recommends that you check with your employer to ensure a policy does exist and that it is followed. If you are not able to resolve this patient safety issue after conferring with your employer, please feel free to contact us back so that we can assess how we might be able to intervene to avert any patients from being harmed.



**Inquiry:** (1) Respiratory Care Protocols: We presently have a respiratory care protocol for mechanical ventilation at our hospital. Within the vent protocol we also have a section for administering respiratory medications for clinical indications as well as drawing ABC's and obtaining respiratory secretions for specific circumstances. With all the new regulations I would like to ask if this is OK. Also, once the protocol is ordered by the physician, is it alright to initiate these other's (ABC, meds) under the physician's order sheet stating, "Initiate Albuterol 4 puffs" per Ventilator Protocol " and my signature. In addition to this, we do state the clinical criteria for initiation under the physician's progress notes. (2) Respiratory Medications: The medical staff and pharmacist at our hospital would like me to set up a policy for RT meds so they do not have to write so much. They have proposed since we give 95% of our tx's in forms of Xopenex, Albuterol, Atrovent tx's in a "commonly prescribed dose", that we dose by default. Ex: HHN Albuterol QID. - Interpretation: 2.5mg Albuterol. Of course I would build the policy to address dosages of each of these unspecified medications. Any higher or lower doses would need the exact dosage. How may this be viewed?

**Response:** The protocol you discussed in your inquiry is fine and is definitely within the scope of practice as outlined in section 3702 of the Respiratory Care Practice Act. It sounds as though you have defined criteria for initiation of the protocol and clinical guidelines that guide the practitioner along the protocol path. This is very appropriate and proven from past and present literature to improve patient outcomes.

The second part of your inquiry regarding medications is not as easy. Both the Practice Act and Title 22 require the medication, its frequency, and the dose be inclusive in the order. Without that detail, the ability of the pharmacist to provide a complete and comprehensive allergy screening cannot be accomplished. Unfortunately, there is no short cutting when it comes to writing a medication order. Despite what your practice is, the medical staff is still required by law to write a clear and complete order.



**Inquiry:** Is a CPR card required to practice respiratory care?

**Response:** There is nothing in the current Practice Act that requires a licensed practitioner to have a CPR card to deliver respiratory care services. However, depending upon where someone is employed there are other state and federal requirements that may include this training. The Board recommends that you make sure you check with all potential agencies prior to ruling out the need for a CPR card.

**Inquiry:** We are a DME Company, JCAHO accredited for only "Medical Equipment Management" and not clinical care of patients. Whenever we get orders to set up Apnea Monitors, before an infant is discharged, an RT has been doing it. However, with the severe shortage of RTs, we might face a situation where we will not be able to complete every order. Our involvement is to set up the equipment on the infant, teach the parents the pertinent information (alarms, weekly testing of equipment, changing the belt, etc.), downloading the monitor and forwarding the report to the physician without interpretation. We do not do patient assessment, clinical care, diagnostic evaluation or interpretation of the reports. Therefore, my question again would be, since there is no clinical care of the infant, and if the technicians have attended classes from the manufacturer, can they do the set-up under the California law? Section 3702 refers more into the clinical care and not just equipment management.

**Response:** Sections 109948 and 109948.1 of the Health and Safety Code wherein (home medical devices) are listed as follows:

- (1) Oxygen delivery systems and pre-filled cylinders.
- (2) Ventilators.
- (3) Continuous Positive Airway Pressure devices (CPAP).
- (4) Respiratory disease management devices.
- (5) Hospital beds and commodes.
- (6) Electronic and computer driven wheelchairs and seating systems.
- (7) Apnea monitors
- (8) Low air loss continuous pressure management devices.
- (9) Transcutaneous Electrical Nerve Stimulator (TENS) units.
- (10) Prescription devices.
- (11) Disposable medical supplies including, but not limited to, incontinence supplies as defined in Section 14125.1 of the Welfare and Institutions Code.
- (12) In vitro diagnostic tests.
- (13) Any other similar device as defined in regulations adopted by the department.

Items numbered 1, 2, 3, 4, 7, and 8 and in some cases items numbered 10 and 13 are associated with the practice of Respiratory Care. Therefore, set-up or application of these devices to a patient or the instruction in the use of the equipment for the purpose of deriving an intended medical benefit must be performed by a licensed Respiratory Care Practitioner or other qualified licensed persons authorized by their respective licensing statute to practice respiratory care. This does not prohibit unlicensed persons from setting up or instructing in the use of the equipment if it is not done for the purpose of deriving an intended medical benefit and is solely restricted to the operation of the equipment (i.e. pointing out locations of switches, filters, etc.). In order to ensure unlicensed personnel are performing legally, any discussion or communication with a patient or caregiver of a prescription or medical condition, in any manner, should be prohibited to safeguard against false accusations of practicing unlawfully and to prevent a patient or caregiver's misperception that unlicensed personnel are qualified to offer medical advice or instruction. If a patient or caregiver initiates such discussion the unlicensed personnel should immediately refer the caregiver or patient to a Respiratory Care Practitioner or other qualified licensed personnel on staff. Unlicensed persons are prohibited from practicing respiratory care in the State of California.



**Inquiry:** We used to have a hard copy in our policies and procedures manual referring to the reordering of meds. (particularly respiratory meds), that stated they must be reordered after 72 hours. That hard copy has gone missing and before I pursue it with our manager, I would like to know if it is a State requirement or just an optional, regional kind of thing. Can you help me?

**Response:** The Board does not regulate the renewal of medication order. However, I believe you will find this information in Title 22, either under the Pharmacy or Patient Care sections of the law. You might be able to get your answer faster if you send an inquiry to the Department of Health Services. Their address is listed below for your convenience:

Department of Health Services,  
714/ 744 P Street,  
Sacramento ,CA 95814  
(916) 445-4171



**Inquiry:** Our respiratory company does several CPAP, BiPAP setups. Recently our Respiratory Therapist asked how long regular visitations should occur for patients, which the insurance has purchased their CPAP or BiPAP or have capped on their rental of the equipment. We currently do the initial setup/visitation then do follow up visitations every 6 months thereafter. We simply do not know how long to carry on with the six month visitations, some of these patients don't even see a doctor regularly anymore, despite our recommendations.

**Response:** Your inquiry is one that should balance patient safety with appropriate business practices. In the case where patients are not seeking regular medical direction from a physician, it would appear that their effort to improve their personal health is not optimal. Unfortunately, not much can be done to make patients do the right thing.

From a clinical perspective, I think it is reasonable to assume that follow-up visits should continue until the patient has reached a specified level of competency with the equipment and its application. Your company can define that competency and would probably have some documentation to validate when that has occurred. Beyond that, the physician who ordered the therapy should be monitoring the patient's progress and determining if additional education or home visits would be useful.



**Inquiry:** I am writing in regard to the inquiry dated Sept. 18, 2002, reference # 2002-C-35 regarding oxygen bars. (See below):

"It is the Board's position that oxygen administration requires a physician's order. It is also clearly stated in the Respiratory Care Practice Act, section 3703 (b) that, 'The practice of respiratory care shall be performed under the supervision of a medical director in accordance with the prescription of a physician and surgeon or pursuant to respiratory care protocols as specified in section 3702.'"

Your response stated that oxygen administration requires a physicians order and also sites the Respiratory Care Practice Act. It sounds like based on your response these oxygen bars are illegal, so I am wondering how they are allowed to exist. Why aren't they being closed down? The employee I spoke to at an oxygen bar said they use oxygen concentrators and said, "You need a medical license to deliver oxygen from a tank but not with a concentrator."

**Response:** The issue of "oxygen bars" operating in California without physicians' orders or oxygen being delivered by unlicensed medical personnel is being reviewed by the Department of Health Services (DHS). While the DHS has not yet taken a position on this issue (as to whether to regulate this practice or prohibit it), it is accepting consumer complaints/concerns. For more information contact: Department of Health Services Food and Drug Branch, MS 7602, P.O. Box 997413, Sacramento, CA 95899-7413, (916) 650-6500.

Please also see the article published on the U.S. Food and Drug Administration's website which provides additional information on this issue. ([http://www.fda.gov/fdac/features/2002/602\\_air.html](http://www.fda.gov/fdac/features/2002/602_air.html))

**Inquiry:** Please advise whether the following excerpt from requested disease-management program (requested from large managed-care org.) raises questions and/or concerns regarding RT's scope of practices.

- (1) On-Call Issues and Communication.
- (2) Patient to be educated on handling COPD exacerbation.
- (3) Triage Hospitalizations via access to Respiratory Therapist with contact information.
- (4) Re-Direction of patient to appropriate health system (i.e., urgent care, ER or Hospital).
- (5) Patients to be given RT's direct phone number to call when experiencing exacerbation.
- (6) RT will then redirect patient as to whether E.R., Urgent Care or Hospitalization is needed.

We are particularly concerned about what seems to be a request to have (our) RT's determine levels of care based upon phone communications with patients. An example given to us posed a situation where a COPD patient, suffering from S.O.B., would contact the RT. The RT would then be expected to determine, based upon the patient's descriptions of his/her difficulties, whether the patient would need to be treated at a facility. The patient would then be advised by the RT, evidently without direct physician involvement, as to the best treatment course of action. Since the main goal of this program would be to reduce "unscheduled" Dr. visits and/or hospitalizations, we are concerned that our participation at the requested levels might place our company (and our RTs) at legal risk. We are a durable medical equipment provider with no home healthcare organizational affiliation.

**Response:** Your inquiry raises great concern regarding the ability of a Respiratory Care Practitioner to assess and triage a patient safely without ANY measurable data or direct patient assessment. It is in conflict with section 3702 (a) of the B&P code that states, "RCP's can provide direct and indirect pulmonary care that is safe, aseptic, preventative, and restorative to the patient". This practice does not appear to be safe for the patient.

From a patient safety perspective, I think this practice will add confusion for the patient. Patients should always be instructed to consult their On-Call Physician or go to an appropriate facility for immediate treatment whenever a patient experiences exacerbation. It has been my clinical experience that many of these patients wait too long to get appropriate treatment, which usually leads to hospitalization.

The Board would not see this practice as safe for the patient and would greatly discourage implementing such a practice. If the Board were to become aware of the managed care organization proposing such a policy it would be the Board's duty to report this unsafe practice to all the appropriate State departments and boards.



**Inquiry:** I know that RCPs can take verbal or telephone orders from a physician. My question is, can an RCP take verbal or telephone orders from a Nurse Practitioner, a Physician Assistant or any other profession? Please let me know. We are only about 2 weeks away from a JCAHO visit and we want to have all of our information correct.

**Response:** Section 3703 (b) states, "The practice of respiratory care shall be performed under the supervision of a medical director in accordance with a prescription of a physician and surgeon or pursuant to respiratory care protocols as specified in section 3702". In the acute care setting, nurse practitioners and physician assistants operate under the direction of their supervising physician. It would therefore not be appropriate to have respiratory practitioners accept verbal orders from them. The practice should be that these providers write their own orders that are then countersigned by their supervising physician.

...continued on page 8

## Scope of Practice Inquiries & Responses

(continued from page 7)

**Inquiry:** I work at a hospital that has a level 2b NICU. This is the closest high-level NICU for 110 miles. For many of our small rural communities, we are the closest and best thing to give them assistance with any newborn in their hospital that is not a "normal newborn". The Neonatologist has asked if it is within the RT scope of practice to be sent to the rural hospital to provide care and stabilize the newborn with the neonatologist in phone contact. Stabilizing the infant would include all NRP guidelines for resuscitation; Intubation, obtaining vascular access including low umbilical veins catheter; Medication preparation and delivery as ordered by the doctor including Epinephrine, Sodium Bicarb, Naloxone, dextrose 10% and volume expanders such as normal saline.

Having multiple RTs in the field delivering high level NICU care to the at-risk newborns would make a large positive impact on stabilization and life long consequence for this group of patients. One neonatologist could positively impact the care of this group of patients with a staff of properly trained and trusted RTs with good skills in the field at their disposal. Is this within the scope of practice if proper training and skill evaluations are documented by the neonatologist?

**Response:** The skills you have described in your inquiry are definitely within the scope of practice of a licensed respiratory care practitioner. For years respiratory practitioners have played an integral part of many transport teams across the country. Both their clinical skills as well as their technical expertise have always made them ideal candidates for this type of work. In addition, the intent of the Practice Act recognizes the existence of overlapping functions between physicians and surgeons, registered nurses, physical therapists, respiratory care practitioners and other licensed health care personnel (3701, Article I, General Provisions). As such, the onus is on the licensed health facility to develop appropriate training and competencies that would provide these functions in a manner that would be safe when administered to the public.

**Inquiry:** In accordance with JCAHO Patient Safety Goals the hospital I work at is preparing a general policy for Critical Value result reporting. Is it within the scope of practice of licensed RCP's to receive Critical Value Test results?

**Response:** It is definitely within the scope of practice for respiratory practitioners to receive critical value results and also act upon those results that are specific to cardiopulmonary diseases and treatment. Results that are not specific to cardiopulmonary should be defined in the policy with the process respiratory practitioners should follow to ensure no critical value fails to get reported appropriately.

**Inquiry:** I'm the Director of Cardiopulmonary Services at a hospital in the State of Nevada. Recently a question has been asked by both Respiratory Therapy and Nursing Services as to what should be done if anything regarding crossing state lines for neonatal transports. On occasion we will transport babies from South Lake Tahoe, Truckee or maybe Susanville back to our hospital. We are clearly acting under the Medical Direction of a Nevada physician and our team consists of a Respiratory Therapist, RN and a neonatal nurse practitioner. We believe this is an issue that takes place throughout the country and we would like to get an opinion from the California licensing board for Respiratory Therapists on this issue. Specifically is a California license required or could some form of reciprocity take effect?

**Response:** Transports across state lines does not require any special licensure for practitioners (Physicians, Nurses or Therapists) because the patient is either being transported from its originating state to a new state, or they are being retrieved from a neighboring state and moved to the state where the practitioners are licensed. In either case, care and practices would be carried out as defined by the state in which the transport team originates from. In your case, Nevada's Practice Act and the policies of the medical facility should be followed from the moment the patient is accepted into your care until the time that care is legally handed over to some other medical facility. There is some general language in California's Title 22 that has some general guidelines for transport teams but nothing specific regarding state to state transfers.

**Inquiry:** The "interdisciplinary practice committee" of our institution has approved an "Albuterol Protocol". Under guidelines & criteria of this protocol, the RCP assesses the patient, chooses among 3 different albuterol administration modes (MDI and 2 different nebulization methods), and adjusts the dose and dosing interval of albuterol according to the severity of the patient's bronchoconstriction state and response to therapy. The RCP writes a "protocol order" for any change in albuterol therapy. Typically, the patient's physician will countersign these "protocol orders". Our questions are: (1) Is this practice allowable under the "Respiratory Care Practice Act" (B&P Code sections 3700-3706). (2) Is physician counter-signature of RCP protocol drug orders necessary (or is the RCP's signature, alone, sufficient to authorize these protocol orders)?

**Response:** The protocol you have described in your inquiry is definitely within the scope of practice of a Respiratory Care Practitioner in California. Section 3702 of the B&P Code specifically defines the protocol you have implemented. From a clinical practice perspective, there are really only two requirements that should be met whenever instituting such a protocol. One is that there is measurable parameters and outcomes that direct the dosing of the medication and two, that the protocol is approved by either the Medical Director of the Respiratory Care Department or some other medical staff committee, such as, interdisciplinary practice or pharmacy and therapeutics.

From an order perspective, I think it is reasonable to have the RCP, as part of the protocol, enter the appropriate assessment data along with the medication dosing as an order. Then it would be a matter of following your own institution's policy regarding co-signature or simply writing the order as a protocol by whoever the approval committee would be. This would meet the Department of Health Service's requirement of having the order on the chart.

*The above determinations do not constitute declaratory decisions under the comprehensive provisions of Government Code sections 11465.10 - 11465.70.*

### Scope of Practice on the Web

A compilation of scope of practice inquiries and responses over the last 2+ years are also available on the Board's website at:

<http://www.rcb.ca.gov/>

Once at this site, select the "Scope of Practice" link on the left side of the home page. Inquiries and responses may be selected by date or by subject.

### Policy on Nondiscrimination on the Basis of Disability and Equal Employment Opportunity Statement

The Respiratory Care Board of California does not discriminate on the basis of disability in employment or in the admission and access to its programs or activities. The Executive Officer of the Board has been designated to coordinate and carry out this agency's compliance with the nondiscrimination requirements of Title II of the Americans with Disabilities Act (ADA). Information concerning the provisions of the ADA, and the rights provided thereunder, are available from the ADA Coordinator.

## Mandatory Reporting

Respiratory care practitioners (RCP) and their employers are required by law to report violations of the Respiratory Care Practice Act and the regulations governing the practice of respiratory care to the Board.

RCPs are required by law to report to the Board any person that may be in violation of, or has violated, any of the laws and regulations administered by the Board. Licensees are required to make such a report to the Board within 10 calendar days from the date he/she knows or should have reasonably known that a violation or probable violation occurred.

Employers are required by law to report to the Board, within 10 days from the date of a suspension or termination of any RCP in their employment, for any one or more of the following causes:

- Use of controlled substances or alcohol that impairs an RCP's ability to safely practice;
- The unlawful sale of controlled substance(s) or prescription item(s);
- Patient neglect, physical harm to a patient, or sexual contact with a patient;
- Falsification of medical records;
- Gross incompetence or negligence, and
- Theft from patients, other employees, or the employer.

RCPs are subject to discipline and can be fined up to \$2,500 and employers are subject to a fine up to \$10,000 for failure to make a report as required. Consideration is given to mitigating and aggravating circumstances surrounding the case.

### How Do I File A Mandatory Reporting Complaint?

Mandatory Reporting Complaint Forms are available on the Board's website at [www.rcb.ca.gov](http://www.rcb.ca.gov) or can be mailed to you, upon request, by contacting the Board toll free at (866) 375-0386.

### What Happens After I've Filed a Mandatory Reporting Complaint?

You will be issued a letter of acknowledgment within 4 days of the receipt of your complaint.

The Board office will determine the appropriate initial action to take such as, a Board investigation, referral to the Division of Investigation, expert review, and/or request for additional facts and information.

After the complaint has been thoroughly investigated and reviewed by the Executive Officer or designated staff, one of the following actions will be taken:

- the case will be forwarded to the Office of the Attorney General for filing of a formal accusation and/or the case may be forwarded to the appropriate District Attorney for criminal action;
- a Citation and Fine will be issued;
- a Warning or Cease and Desist letter will be issued;
- the case is referred to another agency with proper jurisdiction; or
- the case is closed due to insufficient evidence to substantiate the complaint.

Where formal action has been taken by the Board, the subject may face penalties anywhere from a fine, to being placed on probation or outright license revocation.

The Board attempts to notify you at each stage of the investigative and disciplinary stages. Further, you are encouraged to contact the Board office at anytime you would like the status of the case.

## Scholarships

The Board has added a segment to its website to provide information about available scholarships.

If you are aware of an available scholarship, please let us know so we can post it on our website and make mention of it in our newsletters.

## JCAHO Now Certifying Healthcare Staffing Services

In October, 2004 JCAHO launched its Health Care Staffing Services Certification Program (HCSS).

According to JCAHO, it developed the HCSS certification program to meet quality oversight needs that have arisen due to the ongoing shortages of healthcare personnel. These shortages often force healthcare organizations to fill position with temporary employees provided by staffing firms, which are not subject to any quality oversight mechanism. JCAHO will conduct an independent, thorough evaluation of a staffing firm's ability to provide competent staff services and award a Certificate of Distinction to healthcare staffing firms who meet their requirements for certification. For more information, please visit JCAHO's website at [www.jcaho.org](http://www.jcaho.org).

## Respiratory Care In California DVD Now Available!

The Respiratory Care Board (Board) is pleased to have available its outreach DVD entitled *Respiratory Care in California*. The DVD was developed by the Board, and includes a wealth of detailed information ranging from historical facts to employment outlook to the licensing process.

If someone you know is interested in the profession and would like a copy of the DVD, please ask them to contact the Board toll free at (866) 375-0386 or visit its website at [www.rcb.ca.gov](http://www.rcb.ca.gov) and click on the Career in Respiratory Care link.

## Polysomnography, Pulmonary Function Testing, Hyperbaric Oxygen Therapy and Home Care Review Update

In December, the Board approved the Professional Licensing Committee's (PLC's) recommendations related to the practices of Polysomnography, Pulmonary Function Testing and Hyperbaric Oxygen Therapy. The PLC's reports will soon be finalized for submission to the Joint Committee on Boards, Commissions and Consumer Protection at which time they will also be made available on the Board's website.

The Board deferred review of the Home Care report to its March 25, 2005 meeting.

## NATIONAL SLEEP AWARENESS WEEK

MARCH 28 - APRIL 3, 2005

## AARC Establishes Sleep Group and Mailing List

The AARC has announced the establishment of a new group that will allow members interested in or currently working in the field of polysomnographic technology to share information and ideas. The group's first order of business is to establish an electronic mailing list for anyone interested in discussing topics related to polysomnography and sleep medicine. For additional information, or if you are interested in joining the mailing list, please visit the AARC's website at [www.aarc.org](http://www.aarc.org).

## DISCIPLINARY ACTIONS

July 1, 2004 - December 31, 2004

### FINAL DECISIONS

#### REVOKED OR SURRENDERED

Albrecht, Donald, RCP 7554  
Bassett, Daniel Reese, RCP 19104  
Battle-Montoya, Susan, RCP 16238  
Bunce, Polly Catherine, RCP 13506  
Campbell, Shari Lynn, RCP 2295  
Chan, Dennis William, RCP 12160  
Drew, Steve Alan, RCP 16647  
Funk, James William, RCP 21686  
Gobbell, Fred Ray II, RCP 6221  
Goeske, Jimmy, RCP 20604  
Gutierrez, Patricia D., RCP 16912  
Hall, Yvonne Lee, RCP 19913  
Hernandez, Manuel C., RCP 15354  
Horrell, Crystal Ann, RCP 22654  
Hoyt, Nancy J., RCP 8114  
Jantz, Dana Jeanette, RCP 11396  
Jones, Viola Maria, RCP 19621  
Mendoza, Charles L., RCP 16621  
Morris, George Patrick, RCP 1846  
Simpson, Pamela Louise, RCP 13212  
Stewart, Craig Matthew, RCP 21568  
Sullivan, Janice Lorraine, RCP 9765  
Viveros, Christopher R., RCP 22287  
White, John David, RCP 11059  
Wing, Roger M., RCP 10061

#### PLACED ON PROBATION / CONDITIONAL LICENSE

Acosta, Alfieri T., RCP 12869  
Agacer, Austin M. Jr., RCP 7946  
Alexander, Calvin, RCP 23911  
Baldwin, Stanley M., RCP 8779  
Carr, Christine M., RCP 22108  
Catron, Jerry Lee, RCP 20965  
Cunningham, Kim M., RCP 16251  
Diwa, Elmer G., RCP 12948  
Elgin, Leslie, RCP 18628  
Ellis, Kendra Kaye, RCP 22137  
Enyeart, Mark Leroy, RCP 11238  
Fowler, Lorraine Ann, RCP 5464  
Greenwood, Thomas W. RCP 12066  
Jingco, Jon James, RCP 24031  
Kirk, Jody, aka Nielson, RCP 23913  
Koch, Sally J., RCP 21393  
Lewis, Sheryl Elaine, RCP 23815  
Lituco, Cecilio G., RCP 21925  
Marifosque, Edgardo E., RCP 20002  
Mason, Gregory, RCP 23712  
McClung, Suzanne, RCP 8987  
McNair, Leroy C., RCP 6291  
Modelo, Shawn S., RCP 2637  
Okoye, Raphael I., RCP 8636  
Pereyda, Juan Carlos, RCP 20756  
Perry, Frank J., RCP 22674  
Pineira, Ray P., RCP 12417  
Ramirez, Hugo E., RCP 23882  
Rios, John Ambrose, RCP 5442  
Rowell, Scott, RCP 4692  
Stupin, Elizabeth, RCP 6153  
Tana, Alejo M., Jr., RCP 13225  
Watson, Mitchell P., RCP 9271  
Whigham, Carl E., RCP 20619

## ACCUSATIONS

Badesco, Smaranda A., RCP 8656  
Bonelli-Helms, Savina, RCP 5455  
Byers, Angela, RCP 14926  
Cering, Sara W., RCP 18502  
Connolly, Ardie Ray, RCP 18082  
Cyriac, Jolly M., RCP 23089  
De La Pena, Danny C., RCP 21951  
Raymundo, Fernando Jr., RCP 19595  
Garza, Hector, RCP 16332  
Gist, Mary Ann, RCP 21334  
Goulette, Billy J., RCP 7314  
Herrera, Damien Mark, RCP 20799  
Jones, Arlene A., RCP 7989  
Karol, Steven David, RCP 9354  
Kidanu, Teka Tefera, RCP 15066  
Klak, Michael Joseph, RCP 9835  
Krapf, Virginia Ann, RCP 4858  
Mena, Antonio, RCP 17277  
Okabe, Michael Alan, RCP 6734  
Penaranda, Carlos Gabriel, RCP 12459  
Price, Patricia Louise, RCP 8495  
Pueblos, Carlos David, RCP 2441  
Romero, Roger David, RCP 1988  
Rowen, Timothy William, RCP 8018  
Sherman, Mika K., RCP 21980  
Sherrill, Patricia Dawn, RCP 7935  
Thomasson, Michael S., RCP 16785  
Turner, Sean Patrick, RCP 13643

#### ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION

Bolivar, Raymundo, RCP 19262  
Kaplan, Harris, RCP 8118  
Resurreccion, Jamie J., RCP 22742

#### STATEMENTS OF ISSUE

Garcia, Nicolas Joseph  
Lopez, Domingo Francisco  
Patton, James Dean  
Smith, Steven Anthony  
Unutoa, James Scott

## PUBLIC REPRIMANDS

Boone, Vicky, RCP 20925  
Colmer, Bruce R., RCP 10036  
Grijalva, Lanore C., RCP 23912  
Hayer, Harminder K., RCP 19057  
Maldonado, Jesus M., RCP 21756  
Millwee, Fay Ann, RCP 23816  
Paredes, Cathy T., RCP 16057  
Sams, Suzanne M., aka Tobin, RCP 23910  
San Lee, William J., RCP 23741  
Spetnagel, William C., RCP 17762  
Vernon, Dennis A., RCP 23924

#### CITATIONS & FINES

Allder, Walter Robert, RCP 19786  
Aloy, Howard A., RCP 18527  
Berry, William C., RCP 12398  
Brown, Richard L., RCP 21237  
Callahan, William P., RCP 17372  
Caudell, Kimberly R., RCP 18483  
Cepeda, Stephen, RCP 19646  
Coca, Corneliu, RCP 23193  
Cruise, Wendy, aka Rodriguez, RCP 14206  
Cruz, Abner S., RCP 23240  
Edwardson, Raymond E., RCP 8705  
Ferrante, Robert C., RCP 12827  
Fortner, Andrea Q., RCP 22321  
Hall, Joyce E., RCP 21611  
Hanlon, Mariel Sue, RCP 15002  
Hawes, Roger Warren, RCP 4182  
Hill, Erie Vincent, RCP 2635  
Hjelmstrom, Vicki L., RCP 2966  
Holder, Emilie J., RCP 6269  
Hughes, Telly S., RCP 20040  
Jacobson, David M., RCP 13938  
Kavanaugh, John G., RCP 8375  
Langit, Errol, RCP 21823  
Lavato, Jeane L., RCP 16065  
Lynch, Paul D., RCP 6374  
Maeder, Christopher L., RCP 16498  
Malet, Lola Marie, RCP 6257  
Marin, Antonio Omar, RCP 15493  
Martinez, Benjamin, RCP 18429  
Mays, Joe, RCP 1179  
Mendez, Robert D., RCP 16004  
Moen, Stephanie Jean., RCP 17980  
Murphee, Kristina L., RCP 15698  
Park, Casey, RCP 22039  
Paulino, Reron D., RCP 23006  
Princesa, Mary L., RCP 19197  
Pruitt, David Newlight, RCP 19612  
Rogers, LaDonna R., RCP 13371  
Ryan, Susan Marie, RCP 10533  
Salcido, Gabriel Enrique, RCP 21351  
Schwartz, Vincent L., RCP 17303  
Scully, Laura Marie, RCP 13281  
Servillas, Roberto F., RCP 14313  
Shapiro, Irina, RCP 16853  
Sheets, Roberta Marie, RCP 20081  
Shock, Susan F., RCP 15948  
Smith, Zachary Paul, RCP 2698  
Soliman, Tariq, RCP 23334  
Somjit, Micky, RCP 20184  
Spiers, Kelly Vincent, RCP 7817  
Struzinsky, Martha S., RCP 19942  
Taylor-Gendron, Dena, RCP 6354  
Torres, Miguel Angel, RCP 20060  
Valenzuela, Robert L., RCP 23252  
Walker, Brett D., RCP 22843  
Whitmore, Lindsey M., RCP 8400  
Willis, Jessica C., RCP 21995  
Wilson, Stanley Leroy, RCP 6846

### Disciplinary Actions Definitions

Final Decisions become operative on the effective date, except in situations where a stay is ordered.

An **Accusation** is the legal document wherein the charge(s) and allegation(s) against a licensee are formally pled.

A **Statement of Issues** is the legal document wherein the charge(s) and allegation(s) against an applicant are formally pled.

An **Accusation and/or Petition to Revoke Probation** is filed when a licensee is charged with violating the terms or conditions of his or her probation and/or violations of the Respiratory Care Practice Act.

To order copies of legal pleadings, please send a written request, including the respondent's name and license number (if applicable), to the Board's Sacramento office or e-mail address.

## We Want to Hear from You

If you have issues, concerns or ideas you think would better serve the consumers of California or the respiratory care profession, we want to hear from you. E-mails can be addressed to [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov).

### MedWatch-The FDA Safety Information and Adverse Event Reporting Program

The FDA's MedWatch "E-List" delivers clinically important medical product safety alerts and concise, timely information about drugs and devices. Subscription to this service is free and may provide life-saving information for you, your family or your patients. Following are a few of FDA's recent alerts:

#### Bio-Med Patient Tubing Assembly with Adaptor 12/8/04

Bio-Med Devices Inc. voluntarily recalled Patient Breathing Circuits with Catalog Numbers: 80011, 80015, 8002A, 8002A-7, 8002A-9, DENTL, 3030-5, 4408 (built between 9/22/04, and 12/2/04). The device contains a 22mm x 22mm adaptor made, and recalled, by Unomedical, who has found a potential blockage problem which could contribute to serious or life threatening injury to patient. The product is distributed to hospitals and through distributors nationwide.

**IMPORTANT NOTICE OF PREVIOUS RELATED RECALLS:** On 12/2/04, the original 11/30/04 recall notice for two lots of Unomedical's Hospitak airway adapters was expanded to a nationwide warning/recall to include additional Hospitak lots and adapters sold by Viasys, Dräger, and Unomedical. Patients and medical health professionals who have Hospitak, Viasys, Unomedical, Bio-Med Devices and/or Dräger brand airway adapters should check with Unomedical, Inc. before using the product. Patients and health care institutions who are not sure of the origin of the airway adapters they have in stock may want to check with their suppliers to make sure that they are not affected by this recall.

#### Pulmonetic Systems LTV Series of Ventilators, Universal Cable Adaptor 12/9/04

The Universal Cable Adaptor intended to correct an earlier Class I recall of LTV series ventilators, Z-1485-04, is not functioning as intended. The adaptor may not allow the ventilator to be powered up again if the ventilator's internal battery has been depleted or may not be securely attached to the pigtail immediately stop using the recalled devices.

#### Pulmonetic Systems LTV Series of Ventilators 9/30/04

The FDA and Pulmonetic Systems, Inc. notified healthcare professionals of a Class I recall of the LTV series of ventilators, models 1000, 950, 900 and 800, designed to automatically switch to internal battery operation, allowing uninterrupted ventilation, when an external power source is removed or is no longer adequate to power the ventilator. The ventilators malfunction when switching to the internal battery, causing failure of the ventilator to breathe for the patient.

#### Shiley Tracheosoft XLT Extended Length Tracheostomy Tube and Disposable Inner Cannula 8/09/04

The FDA and Nellcor/Tyco notified healthcare professionals of a Class I recall of the Shiley Tracheosoft XLT Extended Length Tracheostomy Tube and Cannula. This recall affects 73,355 disposable units that the firm has shipped to U.S. and international customers over the last four years. The tracheostomy tube is secured in place through the tube's hub and flange assembly with the use of a holder or neck strap. The outer cannula may separate from the hub and neck flange allowing the outer cannula to travel farther into the patient's airway, leading to obstruction of the airway and subsequent lack of ventilation. Airway obstruction or failure to ventilate can lead to permanent neurological injury or death.

If you would like more information on any of these product safety alerts or to review all alerts, visit the FDA's MedWatch website at: [fda.gov/medwatch/index.html](http://fda.gov/medwatch/index.html). To receive immediate updates, subscribe to the "E-List" at: <http://www.fda.gov/medwatch/elist.htm>.

## WE WANT YOUR PHOTOS!



What kind of photos are we looking for? Anything and everything related to the practice of respiratory care! Why do we want these photos? For use in future Board publications such as newsletters, reports and consumer brochures. So please send them in! All respiratory-related photos are acceptable and can be submitted in the traditional format taken with a standard film camera or on a CD if they are from a digital camera.

Any photograph you submit to the Board is considered personal information and cannot be released to the public without your written consent. Accordingly, please provide a signed release for every person in the photograph including any patient(s) or co-worker(s) pictured. The release should state:

I, \_\_\_\_\_, voluntarily consent to the Respiratory Care Board using my photograph in its newsletters, reports, brochures and other related news publications. I understand that my consent will remain in effect until such time that I inform the Board in writing that it has been revoked.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For information on submitting materials electronically, please contact Paula Velasquez at (916) 323-9978 or via e-mail at [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov).

## Respiratory Care Affiliated Resources: Functions and Contact Information

### Respiratory Care Board of California (RCB)

The RCB is the state licensing agency mandated to protect and serve consumers by administering and enforcing the Respiratory Care Practice Act and its regulations in the interest of the safe practice of respiratory care.

#### Contact Information:

444 North 3<sup>rd</sup> Street, Suite 270, Sacramento, CA 95814  
Telephone: (916) 323-9983 / Toll-free: (866) 375-0386  
Website: [www.rcb.ca.gov](http://www.rcb.ca.gov) / E-mail: [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov)

### National Board for Respiratory Care (NBRC)

The NBRC is a voluntary health certifying board which was created in 1960 to evaluate the professional competence of respiratory therapists. The NBRC strives for excellence in providing credentialing examinations and associated services to the respiratory care community. The NBRC offers the following credentials:

Certified Respiratory Therapist (CRT)  
Registered Respiratory Therapist (RRT)  
Certified Pulmonary Function Technologist (CPFT)  
Registered Pulmonary Function Technologist (RPFT)  
Neonatal/Pediatric Respiratory Care Specialist (NPS)

#### Contact Information:

8310 Nieman Road, Lenexa, Kansas 66214  
Telephone: (913) 599-4200  
Website: [www.nbrc.org](http://www.nbrc.org) / E-mail: [NBRC-info@nbrc.org](mailto:NBRC-info@nbrc.org)

### California Society for Respiratory Care (CSRC)

The CSRC is an affiliate of the American Association of Respiratory Care and a non-profit professional organization, whose mission is to represent and encourage excellence in the art and science of cardiopulmonary support. The CSRC is committed to health, healing, and disease prevention in the California community and extends these concepts to its members, students, healthcare professionals, and the public, through education and clinical practice.

#### Contact Information:

1961 Main Street, Suite 246, Watsonville, CA 95076  
Telephone: (831) 763-2772 / Toll-free (888) 730-2772  
Website: [www.csrc.org](http://www.csrc.org) / E-mail: [webmaster@csrc.org](mailto:webmaster@csrc.org)

### American Association for Respiratory Care (AARC)

The AARC is the leading national and international professional association for respiratory care. The AARC encourages and promotes professional excellence, advances the science and practice of respiratory care, and serves as an advocate for patients, their families, the public, the profession and the respiratory therapist.

#### Contact Information

9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063  
Telephone: (972) 243-2272  
Website: [www.aarc.org](http://www.aarc.org) / E-mail: [info@aarc.org](mailto:info@aarc.org)

**Respiratory Care Board of California**  
**444 North 3<sup>rd</sup> Street, Suite 270**  
**Sacramento, CA 95814**

### Address Change Notification

Remember, you must notify the Board in writing if you have changed your address of record within 14 days of such change. Failure to do so could result in a \$25-\$250 fine.

Your written request must include your RCP number, your previous address, your new address, and your signature.

The Board office will accept requests received by U.S. Mail, faxed notifications and changes made via the Board's website.

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