



Boyd Campbell, CBET, CRES
NCBA President

President's Forum

The focus of the North Carolina Biomedical Association has always been to provide quality education and information for Biomedical Technicians, Managers and other support personnel to further themselves in the field. The NCBA Board of Directors met in Myrtle Beach, SC for its annual planning retreat to continue steering the association in the same direction as it has been going for the last 24 years. The largest reason for the success of the NCBA is that each year these groups of motivated and dedicated individuals who strive to build on what the previous group has accomplished. This year is no different. As we got down to business we wanted to develop a plan to take the NCBA into another successful year. 14 separate committees that have specific areas of responsibilities are carrying out this plan. Printed on page two is a list of these committees. These responsibilities range from making sure a quality newsletter gets out in a timely manner, having vendor representation at our annual symposium, planning educational opportunities, and having a web site that is useful and up to date.

There was one question that kept popping up almost rhythmically during the entire meeting... What can we do to add value for the membership? Over the years, before there was a computer on every desk, the main way to stay in touch with the NCBA was the newsletter, which continues to be a valuable source of information. But today with many more resources we have available we have another benefit we are able to offer the membership. If you weren't aware of it, the NCBA has developed its own web site at ncbiomedassoc.com. Need to find a fellow member? Check out the membership section. Want to know what classes the NCBA is offering? Check out the events sections. Couldn't make it to the Symposium this year? Check out the symposium section... You never know whose picture you may find. We encourage you to check it often as it is updated on a regular basis.

In this issue of the NCBA News you will find a fellow BMET who is expanding into the field of research in addition to his regular duties. Also have you thought about how to expand your services? Learn about the method one Hospital has used successfully develop a new repair program. Included is an article from the Joint Commission on a method of taking a proactive of reducing risk. Don't miss the interesting article about what didn't happen.

Also included on page two is a list of those individuals who have volunteered their time and we encourage you to contact them with suggestions and ideas to improve your NCBA.

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NCBA News is an information service of the North Carolina Biomedical Association (NCBA). It has a distribution of about 500 and is published six (6) times per year. Articles and ads are due on or before the first day of odd numbered months. The newsletter is mailed on or about the 15th day of the odd numbered months.

While the NCBA makes every effort to assure that its content is accurate, articles are the products of individual authors and the NCBA is not responsible for the content.

NCBA News intends to disseminate information and ideas to its subscribers. While the NCBA News accurately reflects the source of the articles, the content is of variable quality and validity. The Newsletter Committee will attempt to verify all articles, but neither the Editor nor the NCBA is responsible for information.

YOUR HELP IS NEEDED!!! Articles of interest to our readers are constantly needed and frequently in short supply. If you have written any articles that may be of interest to our readers, submit it to Newsletter Editor, Glenn Scales, at editor@ncbiomedassoc.com.

NCBA Board Meeting Minutes - Friday, March 8, 2002

Duke University Health System, Durham, NC

Present:

Boyd Campbell, Helen Jones, Christina Fleming, Mark Renfroe, Sally Goebel, Charles Worrell, Dale Allman, Brain Poplin, Dan Harrison, Linda Leitch and guests, Jim Tripp, Ed Kubacki, Glenn Scales.

Absent:

Diane Aker

Boyd called the meeting to order at on March 8, 2002 at 10:00 am. He thanked Brian for hosting the meeting. The minutes from the Board retreat on February 8 and 9, 2002 were read. Mark moved for their acceptance, Christina seconded. The minutes were approved.

Treasurer's Report:

Charles reported that our checking account balance as of March 4, 2002 was \$ 16,088.81,

Our CD's were \$23,185.92, and \$23,168.89. The scholarship funds had \$600.00 each and our asset liability (tax) was \$118.99.

The results of the audit conducted on Feb. 1, 2002 were distributed. The records are in good order and no deficiencies were identified. Charles has submitted paperwork to the state for reimbursement of sales tax paid to Pinehurst. Two thousand five hundred dollars is to be reimbursed to the NCBA from the state. Dale moved that we accept the audit as a public document. Linda seconded. The motion carried. Charles reported that our sweep account is actually costing us money to keep. He suggested that we move the checking account from First Citizen's to Central Carolina Bank. Dale made a motion to this affect, Linda seconded. The motion carried.

Action required: Charles to move checking account to CCB.

Membership Report:

Christina reported that the invoices for renewal of membership have been working well. We have 16 new members making our totals 231 individual members, 22 student members, 5 associate members, and 13 honorary members for a grand total of 271 members. Glenn will add the renewal form in an abbreviated version to the website. Dale moved that the membership report be accepted, Mark seconded. The report was accepted.

Action required: Glenn to add membership renewal form to website.

Education Report:

Sally and Linda are working on a Siemens ventilator class. Siemens would be ready to give a one-day introductory class in June. The membership wants the three-day factory class.

Olympus has okayed an endoscope class in August, but could possibly move to June, if we are not doing a Siemens class at that time. The class will not certify people to repair scopes but will equip them to be first responders. Because of the short lead-time we may have to send out flyers to advertise this class. Boyd sent out e-mail to notify us

of his work towards a networking class in the fall, either as a stand-alone or at the symposium. October seems to be a good time for this class. Boyd got a quote of \$ 4000.00

for a two day class. Eric Kershaw was suggested as possible presenter of a networking class for one day of the symposium, and a wireless networking class the next day of the symposium. Linda and Boyd will pursue this.

Sally moved that the education report be accepted, Christina seconded. The report was accepted.

Action required: Linda, Boyd, and Sally to continue to work out a schedule for education.

By-laws: No report.

Newsletter:

The March 2002 newsletter is ready. Glenn needs Boyd's column and the minutes from this meeting.

Dan has been beating the bushes for articles. Glenn needs biographies from Christina and Dale. Glenn has been asking for vendor's input. Charles moved that we accept the newsletter

Continued on page 10

NCBA News is accepting advertising that relates to biomedical equipment and of interest to our readers. Suggested subjects are: Positions Desired, Positions Available, Biomedical Equipment Wanted or For Sale (New or Used), or Announcements of Educational Opportunities or Service Schools in the area.

Advertising is open to all individuals, hospitals, and companies. The decision to carry a particular ad or classified will be the decision of the Editor with support of the NCBA Board. Either jpeg or tiff files of the actual size ads is required. **Corporate Members please remember what free advertisement your membership allows.** Please contact the Newsletter Editor for other pricing.

Prepayment of all advertising is required.

Classified Advertising

Except "Position Wanted" notices by members (one ad per year – limit 50 words – no charge) the following ad rates apply:

<i>(Per 75 words)</i>	<u>Member</u>	<u>Non-member</u>
Individual	\$5. ⁰⁰	\$7. ⁰⁰
Institute	\$15. ⁰⁰	\$25. ⁰⁰
Corporation	\$20. ⁰⁰	\$30. ⁰⁰

Alternate Interaction In Your Facility

by S. Parker Foster

While in BMET school we learn that our options are: working in a hospital, lab or field service. Field service can be for a manufacturer or a third party organization. Our options seem somewhat limited in our realm of practice. I have managed to branch out into uncharted territory this past year with amazing results.

I met Dr. Allan Shang last year in February when he came into my office to borrow a drill. We started talking about the research project he was working on regarding pulse oximetry, and some ideas I had about non-invasive blood gas monitoring. It seemed we had some common ideas and interests. The meeting was purely destiny. He invited me to come see the project he was working on in his lab and asked if I was interested in helping run some of the tests.

The research project is determining the ASTM standard for a baseline of motion artifact rejection in pulse oximetry. When a patient makes movements during saturation monitoring, it disrupts the signal that the oximeter is trying to read. The signal to noise ratio of pulse oximetry is so low to begin with, it is almost impossible to filter out all the noise to get a clean signal. Most of the analysis is performed through advanced concept algorithms.

The hurdle was to get support from my director for time away from my regular responsibilities. He was very excited about the opportunity for the interface between Clinical Engineering and the research end of the medical center. Our agreement was for me to spend a designated amount of time per week and to volunteer an equal amount of personal time toward the project as well.

I was very excited about the chance to work on the project and advance my knowledge of pulse oximetry. I had a basic understanding, but I needed to have complete comprehension of all things oximetry related to associate with everyone involved with the project. Dr. Shang has a master's degree in Biomedical Engineering and an MD with board certification in anesthesiology. He is a very down-to-earth man even with the credentials and background he possesses. I read all of the recent documentation on pulse oximetry research and techniques I could get my hands on. I feel more intelligent having done so.

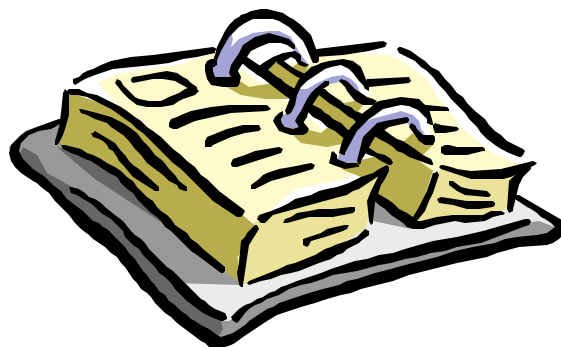
In the year that I have been associated with this project, I have been named Dr. Shang's Research Project Manager, taken a trip to California to analyze our current test methodology and have scheduled a trip to Europe for the International Pulse Oximetry Symposium. The Clinical Engineering Department has also received benefits, mostly intangibles, but they have a more educated technician, better

relationships with the Department of Anesthesiology and publication in medical journals.

We hope to reach fruition by the end of this year and have two other spin-off ideas for the future. There are two other tests that are running concurrent to this project. One is the study of conservation of heat response and temperature exposure. The second is calibration factors for O2 saturations less than 70%. Most oximeters cannot handle such low saturations, but when you deal with ECMO, Sickle Cell and premature births, you often have extremely low oxygen levels.

I have been given a wonderful opportunity to work with such an esteemed medical center, a visionary department and director and to be involved in such important research. I would encourage all of you to pursue involvement in any way possible with the other departments in your facility. It is beneficial to all involved.

S. Parker Foster, Senior BMET
Perioperative Services Team
Duke University Health System



24th Annual Symposium and Expo

When: December 2-4, 2002

Where: Pinehurst Resort and Hotel
Pinehurst, North Carolina

Who: All your friends, professional associates and all our favorite vendors.

Why: Receive critical updates on your profession
20+ training classes and over 80 vendor exhibits
Renew friendships and meet new people

Endoscopy In-House Repair Program Benefits at Alamance Regional Medical Center

by Tony S. Pineyro, CBET, Senior Engineer, Diane Aker, CBET, Director, Clinical Engineering, and staff

So you are thinking about bringing your flex-endoscopic repairs in-house. Great, you've taken the first step in bringing a major medical equipment cost under control. Now there are some hard questions you have to consider before attempting such a venture. With the cost conscious atmosphere of healthcare and start up cost exceeding \$15,000.00 for training and tools, administrators are sure to ask why spend the money? So then why do we consider in-house repairs?

Do your homework. Get some analysis and trending data, (ex. repairs and replacement cost) to support your quest. What types of failures are you having and are they avoidable? What is your current scope inventory availability and number of cases for each? Most important, what are your staff and physician satisfaction ratings with your current program?

After researching the answers to most of those questions and compiling two full years of trending data, we decided to take the plunge and bring the repair program in-house. Our manufacturer offered a two-phase partnership training program (program completion allows you to purchase manufacture repair parts and tools) which seemed to best fit our needs. At the very least we knew that we could better negotiate the current repair requests and repair vendors, after receiving the endoscopic repair training.

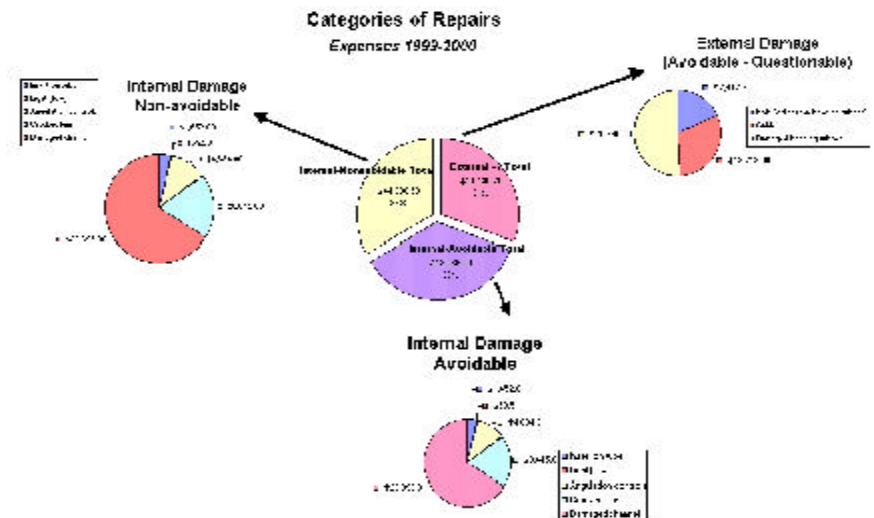
Benefits that were a direct result of the program started to show up in the first quarter. Some of the most note-worthy are listed below:

1. **A Planned Maintenance Program** helped in correcting potential problems before becoming major repairs (ex. chipped or leaking glue, bent nozzles, chipped lens, peeling insertion tubes, and angulation problems) which keeps scopes in like new condition.
2. Program has helped **identify trends** and problem areas. For an example, the identification and repairing of leaking scope caps has resulted in an 80% drop in fluid invasions.
3. Involvement and responsiveness from engineering has helped to identify **operator errors** and paved the way for **inservices** on proper handling, processing and storage of scopes. This has proven to be useful in team building, improved

interdepartmental relations, and communications for our department.

4. **Repair turnaround time**, in most cases, is same or next-day service.
5. **Repair Costs** have significantly decreased since startup of the program in March 2001. Since then, only thirteen scopes have been sent out for repair verses fifteen in the month of January 2001 alone. The part of the program that gives our financial administrator the warm fuzzies is the cost avoidance analysis. In 1999 we had an all time high cost of **\$47.11 per case** (19 scopes) for scope repair and replacement. In 2001 our program cut this expenditure to **\$16.92 per case** (25 scopes) or a 60% decrease per case. We also brought our scope availability up from a low of 92.91% to 97.89% to date. Scope availability equates to earnings potential.
6. Realizing our primary objective is **Improved Patient Care** we used the following indicators to help track our performance. Less down time, increased scope availability, and prompt response to repair request has reduced scheduling conflicts with little or no patient waiting. All of these along with improved quality have assured patient comfort and greater physician satisfaction.

Any Biomedical or Clinical Engineering looking to justify their existence or add depth to their Repair & PM program should take a good, long, and hard look at in-house Endoscopy Repair.



Using FMEA to Assess and Reduce Error Risk

Its name may be intimidating, but Failure Mode, Effects and Criticality Analysis (FMEA) offers an extremely powerful approach to proactive risk assessment and reduction and can be easily learned by health care professionals. “FMEA is a straightforward, common sense methodology that has been around for decades because it works,” says Richard Croteau, MD, JCAHO executive director for strategic initiatives.

FMEA Basics

Extensively used in the aerospace, nuclear, manufacturing, and chemical industries, FMEA is a systematic way of examining a design prospectively to find possible ways in which failure can occur. The technique involves identifying potential mistakes before they happen to determine whether the consequences of those mistakes would be tolerable or intolerable. Potential failures are identified in terms of failure “modes,” or symptoms. For each mode, the effect on the total system is studied. When potential effects are intolerable, actions are taken to eliminate the possibility of error, stop an error before it reaches people, or minimize the consequences of an error. Then the action or actions being taken or planned to minimize the probability or effect of failure are reviewed.

FMEA assumes that no matter how knowledgeable or careful people are, errors will occur in some situations and may even be likely to occur. The focus is on what allowed the error to occur, rather than who. In designing systems and processes, engineers begin with the premise that anything can and will go wrong. Their role is a proactive one – to design accordingly. This view of errors represents a different mindset from the still pervasive view in health care that errors are the result of individual human failure. “Unfortunately, health care processes tend to be designed based on the premise that nothing will go wrong. The assumption is that properly educated and trained health care professionals will not make mistakes.” says Croceau.

A New View of Error Causation

JCAHO’s new patient safety standards (effective now for hospitals and in the future for other health care settings) challenge organizations to change this mindset by adopting the engineering model of error causation. A new Leadership standard (LD.5.2) requires leaders to provide direction and resources to develop and implement proactive risk assessment activities so that processes, functions, and services can be designed or redesigned to prevent errors. As stated in the intent, proactive identification and management of potential risks to patient safety have the obvious advantage preventing adverse occurrences rather than simply reacting when they occur. “The real advantage of assessing risk prospectively is that the barriers – such as fear of disclosure, blame,

punishment, and intimidation, that are so prevalent in investigations following an actual bad outcome – are absent,” says Croteau. “Staff can throw themselves into FMEA with a positive attitude because they actually are going to prevent bad things from happening.” A team approach is critical, notes Croceau.

At least annually, organizations must select at least one high-risk process for proactive risk assessment using FMEA, although this approach does not exclude other approaches, Croteau says. The selection should be based, in part, on information published periodically by JCAHO that identifies the most frequently occurring types of sentinel events and patient safety risk factors. The intent is to help health care shift from a reactive patient safety orientation to a proactive one and introduce tools to make that shift possible. The steps involved in using FMEA appear in the review below.

Steps for Conducting Failure Mode, Effects, and Criticality Analysis

1. Annually select at least one high-risk process.
2. Diagram intended and actual implementation of the process.
3. Identify the steps in the process where there is, or may be, undesirable variation (failure modes).
4. For each identified failure mode, identify the possible effects on patients and the criticality of the failure mode.
5. For the most critical failure modes, conduct a root cause analysis to determine why the variation (the failure mode) leading to that effect may occur.
6. Redesign the process and/or underlying systems to minimize the risk of that failure mode or to protect patients from its effects.
7. Test and implement the redesigned process.
8. Identify and implement measures of the effectiveness of the redesigned process.
9. Implement a strategy for maintaining the effectiveness of the redesigned process over time.



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Thank You from Caldwell Community College

Caldwell Community College would like to thank the NCBA board of directors and the general membership for the financial support you have provided the biomedical equipment technology program. This financial assistance has enabled us to purchase items we otherwise would have not been able to afford. We are always striving to provide the best education possible here at Caldwell Community College and with the addition of tools, repair parts and training aids we will continue to educate quality technicians.

Caldwell Community College and Technical Institute was awarded one of five superior ratings among the 58 NC Community Colleges in 2001. The performance standards to achieve this rating are as diverse as the student population. Areas such as progress of basic skills students, passing rates on licensure and certification exams, student goal completion, employment status of graduates, and performance of college transfer students and program satisfaction are all considered for this prestigious award. With the financial help provided by NCBA it makes meeting our performance standards much easier.

NCBA donations have allowed the college to replace many of the older tool sets including quality multimeters and soldering irons. I no longer have to explain to students doing electronic labs that they can't measure the current because the meter won't measure a current that small. Repair parts have also been purchased so we can do board level repairs on equipment such as Marquette/Corometrics fetal monitors, HP defibrillators and other equipment in the biomedical lab. Training aids in the form of educational videos and software have also been purchased. We now have training videos in the areas of anatomy and physiology and chemistry. We also have purchased Fluke cable testers for networks and software to troubleshoot network systems. We currently still have some funds, which will be used to update other areas of the BMET program. I am currently looking for training aids in laboratory equipment. This seems to be an area in which better training can be provided. Your support enables us to upgrade our educational offerings.

From the current students to future students, and from myself I would once again like to thank each of you for your continued support of Caldwell Community College and the BMET program.

Thank you, John Noblitt, CBET
Program Director/BMET
Caldwell Community College And Technical Institute

Computer Tech Tips, Part 2

by Glenn Scales, CBET

When Two Is Better Than One

By default, when you double-click a Windows 95/98 folder icon, the folder's contents appear in a single-paned window. If you prefer the dual-paned view, you can right-click a folder and select Explore. Do you find yourself going the two-paned route most of the time? Then change a folder's default action from Open to Explore. From then on, double-clicking a folder automatically opens its contents in a two-paned "Explorer" window.

Inside any Explorer window (single or double paned), select View, Options, then click the File Types tab. In the list of Registered file types, select Folder and click Edit. Under Actions, you'll see Open in bold (to indicate the current default action). Select Explore, click Set Default, and now Explore will appear in bold. Mission complete. Click Close twice to keep the change, then double-click any folder to try it out! (Tip: To open a window in a single-paned view, right-mouse-click it and select Open.)

Start Menu Folders

If you access your Control Panel or your Printer folder on a regular basis, you may find it more convenient to have it configured as a drop-down menu item on the Start menu.

To create any of these special folders, you will need to create a new folder in your Start menu named exactly (and I mean exactly) as shown below. To do so, right-click on the Start icon and select Explore. An Explorer window will open showing the contents of the Start menu. Right-click in the right hand pane and select New-Folder. Change the title "New Folder" to one of the four items listed below.

```
Control Panel.{21EC2020-3AEA-1069-A2DD-08002B30309D}
```

```
DUN.{992CFFA0-F557-101A-88EC-00DD010CCC48}
```

```
Internet History.{FF393560-C2A7-11CF-BFF4-444553540000}
```

```
Printers.{2227A280-3AEA-1069-A2DE-08002B30309D}
```

Now, when you click on the Start menu, you will see your new folder and as your mouse hovers over the folder, a drop-down list of your Control panel or Printers will pop up. Be warned: if you add the Internet History folder to your Start menu, you'll probably want to empty your History folder on a regular basis, to keep this list under control.

If you don't like what you have done, just open the Start folder and delete the special folder you created. This is nothing more than a special kind of shortcut and you are not deleting the original files.

Start Menu Clutter

If you install a lot of programs in Windows and allow Windows to use the default installation settings, you may find that your Start menu has grown considerably over the years. Sometimes to the point that you can't easily find anything. Well, it's time for a little housecleaning.

First of all, you most likely don't need to have every separate program in its own individual folder. In many cases, the folder contains the application icon, plus an uninstall icon, lots of readme's and license agreements, plus links to files and documents you will rarely use. Even if you occasionally need them, it's just as easy to open Explorer and go directly to the folder.

I have saved myself a lot of space by creating several generic folders in the Program folder of my Start menu, such as Applications, Utilities, Graphics. What you set up is based on your likes, work habits and desires. You can then go to a specific application folder and drag the main application icon from the folder that Windows installed to one of your generic folders. For instance, my Applications folder contains icons for Word, Excel, Photoshop, FileMaker Pro, Visio, etc. In that way I can go to one generic folder and find most of my common applications.

Once you have your generic folders configured the way you like, just delete the old application folder from the Programs folder. Remember, you are only deleting the shortcuts – not the original files. By the way, did you know that you can drag folders and files within the Start menu to where you want them. You can reorganize your folders and files exactly how you want them, rather than the automatic alphabetical sorting that Windows does. Just click, drag and drop – try it and you'll see how easy it is to customize your Start menu and make it work better for you.

One-Click Exits

Want an fast, easy way to shut down Windows? Right-click the desktop and choose New, Shortcut. Then type `c:\windows\rundll.exe user.exe,exitwindows` (your path may differ), click Next, type a name for the shortcut, such as Exit, and click Finish. Double-click this icon anytime to exit Windows and shut down.

To create a keyboard shortcut for exiting, right-click the icon, select Properties from the menu, click the Shortcut tab, and click in the Shortcut key box. Press the keys you want to use to activate your shutdown shortcut (they must begin with *Ctrl-Alt*, *Ctrl-Shift*, or *Shift-Alt* and should end with some letter). As you press the key combination, it will be displayed for you in the shortcut key box.

If you want a shortcut that restarts Windows rather than simply shutting it down, change the command line in the Target box to read `c:\windows\rundll.exe user.exe, exitwindowsexec` (your path may differ).

Dollars and Sense

By Charles Worrell, NCBA Treasurer

Account balances as of March 4, 2002:

Checking:		\$16,088.81
CD's:	XX205	23,185.92 *
	XX257	23,168.89 *
Scholarships:	Eddie Whisnant	600.00 ‡
	Norm Reeves	600.00 ‡
Asset Liability (tax)		118.99

* At the time of this report, we have not received a February interest statement.

‡ Monies are not transferred to these until the month before the Symposium

Due to our cash flow cycle, based our current Symposium dates, the Board of Directors has approved our fiscal year change to April 1 through March 31. This will capture the Symposium income and expenses for just one Symposium. In the past, expenses for the previous Symposium were carried over to the next year because of the fiscal year dates. This caused our "Profit and Loss" statement to be in the "red", when in reality, we have always been in the "black".

A special thanks to members Ed Struble and Jerry Kyle for their assistance in the annual financial January audit.



The Business Meeting for Healthcare Technology Professionals

Don't miss today's leading companies
in the HealthTech exhibit hall:
(Apr 21 - 23, 2002)

- AFSM International
- ACCE
- Amronix Inc.
- Aesca Information
- BC Group International
- Bio-Tec Instruments
- Capella
- Data Exchange Corporation
- Jatech-Chimeda
- DITEC
- DNI Nevada, Inc.
- Dunko
- EMCON CMA, Inc.
- Intra-Access Software Systems, Inc.
- ICH Medical Systems
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- Huestis Medical
- NI
- MedEquip Biomedica
- Merrad Inc.
- Netcor
- Modern Biomedical & Imaging
- Nocooh Corp.
- NovaMed Corp.
- OHP-C Instruments
- ParkScan
- Patient Medical Technologies
- Philips Medical Systems of America
- Precision Philosophy of America
- Prime Development Corporation
- Quality Monitor Systems
- Reser M/D
- Service 300
- Sonora Medical Systems
- St. Charles Systems, Inc.
- Stephens International Recruiting, Inc.
- Technology in Medicine
- Teroid Corporation of Maryland
- TriMed
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KEYNOTE SPEAKERS

MONDAY, April 22

Diane Darling
President
Lifetec Networking, Inc.

*Turbo Networking for
a Successful Conference*

TUESDAY, April 23

James Lussier
President & CEO
St. Charles Medical Center

*21st Century Healthcare
Organizations - Maximizing
Creativity, Innovation and Mission*

Here are some of the many sessions
taking place at HealthTech 2002:

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- Regulations for Third-Party Repair Facilities/ISCs
- Streamlining DICOM for Interoperability
- An In-house Look at Remote Diagnostics
- Practical Database Report Generation
- Leadership 101 - How to Effectively Manage You + Staff
- Project Management for Test Initial Management
- HIPAA Update

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NCBA Board Minutes (continued)

report, Dan seconded. The report was accepted.

Action required: Boyd's to submit column to Glenn, Helen to submit minutes to Glenn, Boyd to call Bob Larkin.

Nominating Committee: No report.

Old Business:

The board was not sure that a certificate showing years of membership really constituted a great value to our members. Having the attention of hospital management focused on biomedical and what we do would be of value to all.

New business:

Christina reported that the laptop computer she had been using had crashed and requested that the NCBA consider buying one for the use of the membership secretary. Dale, Helen, and Christina were appointed to look into the prices and capabilities of laptops and get back to the board with a recommendation.

Glenn will be putting student's resumes on the website. The board will test out the list serve that Glenn is working on to see if this is something we want to offer to the NCBA members.

Action required: Dale, Christina, Helen to research laptops, Glenn to put resumes and list serve on the website.

Symposium Planning:

Helen reported that we will be meeting with the hotel before the May board meeting to set a contract for 2003.

Education: Linda is working on classes with GE networking, Drager infant warmer, Ohmeda Giraffe, Welch-Allyn Propaq, Ditec, Valleylab, Laser Imager Printer.

Keynote: Brian will suggest some names from the list he had compiled last year.

Vendor relations: Mark submitted his new vendor form for review. There was much praise for Mark's work. This form eliminates the uncertainty that has existed with previous forms. Helen is to get the hotel reservation form to Mark so that it may become part of the vendor mailing.

Membership had no concerns regarding the symposium.

Charles and Dale showed the board the proposed budget. Charles will polish it up and distribute it to the board.

Action required: Helen to set meeting with hotel, Linda to continue working on classes, Brian to suggest names for keynote, Helen to get hotel form e-mailed to Mark and Glenn, Charles to submit budget.

Dan Harrison moved that we adjourn, Sally seconded. The meeting was adjourned at 3:15pm.

Siemens Servo 300 Training

The North Carolina Biomedical Association is offering two training classes on the Siemens 300 Series Ventilator. The class will be held at the Siemens Training Facilities in Cary, NC. The class length is two days and there will be two different class dates available: May 20th & 21st or May 29th & 30th. **Please note that if the minimum number of 6 people per class is not met, the two class dates will be combined in one class.** Deadline for registration is May 3rd. For more information check out the website at www.ncbiomedassoc.com or contact Linda Leitch at vicepres@ncbiomedassoc.com or 919-681-4293.

Introducing Crisci Fleming

As your newest Board Member, I would like to introduce myself. Since graduating from Caldwell Community College in 1999, I have worked at FirstHealth Moore Regional Hospital in Pinehurst, NC.



There has been a lot to learn at Moore Regional. Not only have we had to learn the hospital's equipment, but also the limitations of the people using that equipment. Communication skills have had to be sharpened along with troubleshooting skills. Having only one or the other would make us much less effectual. Then again, this is why we are respected by doctors, clinicians, and patients. We provide services they cannot provide for themselves.

Membership in NCBA has been a valuable part of my training. I hope that you will feel your membership has been as valuable to you. Please let me know how I can be of assistance to you as your Membership Secretary. My "door" is always open.

The Story of What *Didn't* Happen

by Hunter Watson, Duke Univ. Health System

The fire didn't start that night at Hendricks Regional Medical Center. The fire didn't start inside the power supply of a ventilator in room 14 of the Surgical ICU. It didn't sweep through the oxygen-enriched environment of two adjacent patient rooms. Three patients, one RN and a visitor didn't die at 9:15 PM that night because the fire didn't start.

The large cap on the power supply assembly did not overheat that night in the ICU. Bed linen dust sucked in by the ventilator's intake fan and accumulated in layer upon layer from months of constant use did not reach critical temperature that night. The cap didn't overheat. The dust didn't ignite. The fire didn't start.

John Balfour, a BMET with 6 years experience at Hendricks, extinguished the fire three months prior during a routine PM procedure. As part of a boring, mundane procedure he vacuumed out the dust inside the ventilator's card cage.

Linda Worthington, a BMET and a service technician for the ventilator manufacturer, put out the fire two months before it started by responding promptly to her company's recall of a faulty power supply.

Three patients lived that night to go home and tell about the horrors of hospital food and show off ugly surgical scars. One RN lived to attend her wedding the following week. One visitor went home and put out fires as a volunteer fireman for his small town.

Catastrophic events with medical devices usually involve several major mistakes or problems.. In 1989, a fire swept through a surgical intensive care unit killing three patients, an RN and a visitor. Accumulated dust and a faulty ventilator power supply still in place after a factory recall were implicated in the fire.

Information Update Request

Please remember that if you move, change jobs, change phone numbers or e-mail addresses, send an update to the NCBA. All changes can be sent to Christina Fleming at e-mail address memb_sec@ncbiomedassoc.com or by phone at 910-215-5178 (Moore Regional Hospital). Any changes for the web site can be sent to Glenn Scales at webmaster@ncbiomedassoc.com or phone 919-681-6638.

Privacy Note: Member information is released only to registered NCBA Vendors and only business contact information is provided. Under no circumstances is information provided for the purpose of marketing inappropriate material or services.



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SCHEDULE of NCBA BOARD of DIRECTORS MEETINGS for 2002

March 8, 2002, Time: 10:00 a.m.
Duke University Hospital, Durham, NC
Host - Brian Poplin, Ph: 919-681-2525

May 10, 2002, Time: 10:00 a.m.
Wayne Memorial Hospital, Goldsboro, NC
Host – Mark Renfroe, Ph: 919-731-6077

July 12, 2002, Time: 10:00 a.m.
Catawba Memorial Hospital, Hickory, NC
Host - Boyd Campbell, Ph: 828-326-3899

September 13, 2002, Time: 10:00 a.m.
Premier, Charlotte, NC
Host - Dale Allman, Ph: 800-825-1786

November 8, 2002, Time: 10:00 a.m.
Pinehurst Resort & Hotel, Pinehurst, NC
Ph: 800-487-4653, www.pinehurst.com

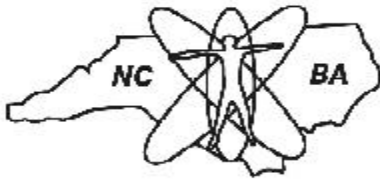
December 2-4, 2002
2002 NCBA Symposium and Expo
Pinehurst Resort & Hotel, Pinehurst, NC

January 10, 2003, Time: 10:00 a.m.
NC Baptist Hospital, Winston-Salem, NC
Host – Helen Jones, Ph: 336-716-612

February 7-8, 2003, Time 8:30 a.m.
Board of Directors Planning Retreat
Myrtle Beach, SC

Board Meetings are open to the NCBA Membership. Please plan to attend.

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