

Respiratory Therapists Can Facilitate Positive Change with Institutional Support

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Abstract

Many of the respiratory therapists (RTs), also known as respiratory care practitioners (RCPs), today feel overwhelmed and are rapidly becoming burned out. Respiratory therapists are given a list of task and are expected to complete them no matter what else arises. This approach, in the management of RT patients, does not work for anyone involved. The RTs rarely have enough time to get everything done, and do it proficiently, and patients continue to complain about missed therapy. Family members are disgusted, and hold bedside vigils to ensure adequate care is provided. Education is the key to fixing the problems in today's health care industry. Education of the patients, families, and the practitioner with the goal of becoming great providers should be at the forefront of respiratory care in every hospital.

INTRODUCTION

The purpose of this professional writing is to inform and plead with managing officers, the overwhelming tolls placed on the staff respiratory therapist. The entire corporation needs to be made aware of the staffing shortage crisis in this field of respiratory care. Department leaders are finding solutions to the problem via therapist driven protocols, and by incorporating retention efforts. The efforts of managers are just beginning to aide in fixing the problem, however much work is left to be done and it must start within the departments.

The demands of today's RT calls for a new generation of therapist armed with critical thinking skills, time management, and professionalism. The caliber of therapist coming out of school today has to change to meet the demands. As the field continues to evolve, respiratory schools will have to do a better job of preparing students, particularly with their assessment skills and knowledge of ventilator equipment (Daus, 2000).

LITERATURE REVIEW

RT's have a positive role in the hospital today, interacting with patients through education, and offering different community based classes. A RT's knowledge at the bedside can teach tips on how to relieve respiratory distress with breathing exercises. One thing remains a constant in the field, the expected pace is too fast, many people have opted

to give up on the profession because of its overwhelming nature. When staffing resources permit respiratory therapy departments continues to be very resourceful tools in the healthcare arsenal.

An individual requiring the services of a respiratory therapy is simply any person who has any impairment with breathing. Therefore, the disease or diagnosis of the patient is not relevant to the need for care by RT, if the patients breathing is exacerbated or breathing is absent. Studies show people over the age of 65 make up one of the fastest-growing segments of the population, and they tend to acquire more chronic diseases. With a significant rise in the number of chronic pulmonary diseases patients, there should be a corresponding increase in the demand of RCPs, particularly in long-term care facilities (Myers, 1999).

Arguments within the RT community, as to whether a distinction should be made between registered and certified therapists are rarely a concern when the work levels exceed the staff present to complete the tasks. Studies have shown that RTs having more than 12 patients run into problems with time constraints. RT's in large hospitals, 86% report an adverse impact on quality of care, and 67% say patients have been placed at risk; for those with more than 12 patients 85% report an adverse impact on quality of care, and 61% say patients have been placed at risk (Hart, 2002).

The staffing crisis in the profession will only increase with

these statistics making recruitment and retention a vital role in alleviating the looming disaster. The vacancy rate in hospitals grew from about 6% in 2000 to nearly 9% in 2005. That means a current shortage of nearly 12,000 respiratory therapists (News, RT for decision Makers in Respiratory Care, 10/27/06).

The problem of retention is exacerbated when a therapist feel as though there is just not enough time in a day to get the task done. With hospital today offering sign on bonuses from fifteen hundred to fifteen thousand, for a three year commitment, retaining employees has become a challenge. Retention efforts have lead to many articles in such professional journals as Advance, and RT for decision makers in respiratory care. Listed below are a few from the listed journals and their suggestions in the retention of staff:

1. Hosting an awards dinner and include employee's families.
2. Invent a department slogan different from the hospitals.
3. Distribute coffee cups bearing your department's name.
4. As a fund-raiser, make a photo calendar of workers pets.
5. Schedule fun, wholesome family activities like bowling, face painting yard sales and antique collecting. And have a certified babysitter available.
6. Have a group photo taken and place it on a cake or make a jigsaw puzzle out of it.
7. Start a department lottery (if legal) (Wise, 2008).

Each facility is left with figuring out recruitment efforts, and at the same time not overlooking retention ensuring knowledgeable staff remains. In order to keep the employees happy some retention practices should be thought of daily. The scheduling of breaks, or break partnering people to relieve each other, should be part of making the assignment. Daily overworking staff is unacceptable but, during times of high hospital census, this factor cannot be avoided. Some managers have come up with ideas of rewarding staff, with complimentary breakfast, on these days. These efforts show the staff that the administration cares, and that they appreciate everyone's hard work. Others offer psychological

counseling: pre-work relaxation sessions with soothing music and positive words, relaxing colors, and comforting incense: classes on stress, anger and time management; and memory enhancement and expressionism classes (Wise 2008).

Guidelines for staffing are based off of a points system and are assessed continually by the charge respiratory therapist or the manager of the department. These total factors make up the respiratory acuity. Respiratory acuity is the total assignable points and is dependent therapy ordered. Departments depend on a way to count up the amount of work, as a tool, to know how many people are needed to get the job done. What is valued as a point is solely at the discretion of the department managers. A nebulizer is considered one point and could take seven to fifteen minutes to assess, start, and finish while a ventilator can be three to four points. Listed below are tasks preformed which usually have a point value: pulse oximetry, chest physiotherapy, postural drainage, bronchodilatation, and monitoring of mechanical ventilated patients.

On the other hand the majority of tasks have a decreased point value or no value at all. Tasks without points include: emergencies, code blues, arterial blood gas sampling, and assessment of a deteriorating patients. Emergencies should be expected to happen within the hospital and provisions made along with time allotted to react appropriately. There were approximately 1.1 million intubations and mechanical ventilation procedures performed in 2003 (Enge, 2008). That would mean 1.1 million unscheduled therapies requiring respiratory service to be present. Educational duties are preformed daily and there should also be an allotted point value placed on the following tasks. The time it takes to educate patients and answer questions from the family. This education time would also include teaching the new nurse how to use and incentive spirometer or nasotracheal suctioning. As well as the time RT's needs to ensure that there is not an accidental extubation of the 30 weeker whose parents get to hold for the first time. The Joint Commission on Accreditation of Healthcare Organizations has urged hospitals to develop more multidisciplinary teams that address patient education, primarily because shortened hospital stays have increased the need for strong patient education programs (Daus, 2000)

The acuity should also be based on the number of critical care areas that facility has to cover. The skill level of the RT's present should play an important factor in deciding staffing ratios. Dangerous scenarios could play out when one

RT is expected to cover more than one critical care area, it is impossible for one person to be in two places at the same time.

The surmounting yet emergent task tends to lead to the failure of scheduled therapy. Often, therapies are completely omitted due to other patient care priorities in other areas (Darnley, 2007). Whether it is due to the lack of time or staffing, the relayed message to therapist is not that the patient is in distress but that the therapy ordered was not given. In many cases, by the time the prescribed therapy is preformed, the status of the patient has changed and the ordered therapy has become inappropriate (Darnley, 2007). For the 100 patient records examined, the findings for aerosol treatments were as follows: 61% of patients received therapy that was too frequent; 7% therapy was not appropriate; 3% initially too frequent but later appropriate; 3% initially insufficient and later excessive; 2% excessive initially and later insufficient; 13% initially appropriate and later excessive; and 11% appropriate during the entire hospital stay. The study provided data resulting in \$49,630 for unneeded aerosol therapy in a three month period (Goddard, 1998).

With a known staffing deficiency and daunting task one solution that has been presented is the need for respiratory driven protocols. The intervention of RT, whether the patient is seen on arrival to the hospital or every 12 hours, allows the therapist to assess and administer the appropriate therapy. The protocols allow the therapist to intervene with patients who may be developing problems before they begin to deteriorate severely, necessitating a code being called (Darnley, 2007). Things like aerosols and CPTs dropped from 7,500 to 2,500 within the first three years of the study at a hospital in California. As a result of all the savings (and here's when the staff therapist start putting together the protocol data to convince the administration), the department was allotted more money for salary increases (Miller, 2007).

Protocols can also aide in the broken line of communication, among physicians, nurses, and respiratory therapist, when therapists are involved in patient's rounds. This interaction has also allowed an increase in respect from the medical staff. Protocols magnify the use of the skill taught to the therapist boosting their confidence and department morale. Most staff knows, they can ask for our opinion, we are with the patients and see which modalities work (Miller, 2007). However, because the importance and value of respiratory therapists are underestimated, respiratory caregivers are eliminated from the decision-making process (Darnley,

2007). The respiratory therapist are many times the road blocks because they don't believe they're the best person to do this, RTs need to remember that they are the only profession trained to do respiratory care modalities (Miller, 2007). RTs unique and resourceful opinion have changed the outcome of most patients and decreased to length of stay in the hospital.

DISCUSSION

Hospitals report an average 5.2% profit margin in 2004, the last year of data available from the American Hospital Association (Appleby, 2006). For example, a profit of fifty thousand dollars for every one million made. Profits remain steady even when most hospitals are under construction trying to make their environment more comfortable. These facilities are hearing the request for privacy and are turning all double occupancy rooms into single occupancy. This will undoubtedly raised the cost of an overnight stay in the hospital. The ongoing construction has not affected profit, though once new facilities come on line; overall revenue might increase for the industry (Appleby, 2006). Although some facilities struggle with Medicare payment and cutback the profit margin speak for it selves. With emergency room business booming the American Hospital Association's Annual Survey states 3.6 million more people served in 2006 than those years prior totaling 118.4 million served in 2006(Gibbons, 2007). Health care is a business, there is no time to be a Florence Nightingales, productivity is profitable so get out there and get it done.

CONCLUSION

Therapist driven protocols are bridging the relationship between MD's, RN's and RT's. The lines of communication are open and the patient is receiving a team approach to care. Finally, the success of protocols, in many facilities, has somewhat aided in alleviating the staffing shortage crisis felt in the hospitals. A major barrier, in the executing of therapist-driven protocols, is a lack of resources. Short-staffed hospitals have neither the time to invest to create the protocol program nor enough therapists to help carry them out (Miller, 2007). Continue to train yourself in effort to keep up with the demands of the job. New graduates need to be equipped with critical thinking skills so that they may take the reins in the hospital. RT veterans should always speak positive of the profession and make others curious as to what we do. A RT's training is exclusive we are not just gas passer, and snot suckers we are professionally trained in Oxygen therapy and pulmonary toiletry.

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