SUBJECT: Patient Care Policies

Effective Date: June 30, 1990
Revised Date: December 2009

I. General Policies
A. Any therapeutic procedure performed, drug administered, or changes made in delivered respiratory therapy must be ordered by a licensed physician having privileges at UMC. Limited verbal or telephone orders for therapy can be taken and noted on the Doctor’s Order Form by Licensed Respiratory Care Practitioners.
B. Procedures routinely performed without specific orders from a physician must be delineated in the appropriate protocol for respiratory care.
C. Therapies will be administered as outlined in Appendix A- Respiratory Care Clinical Assessment Skill Checklist.

II. Exceptional Limitations
The following information lists any restrictions and/or exceptional requirements associated with each therapy:

1. Incentive Spirometry
   a. The patient’s target volume will be set according to the inspiratory capacity volume goal as indicated by the package nomogram.
   b. The date, time, mode of therapy, achieved inspiratory volume characteristics of any sputum production, breath sounds, and indications of effective cough shall be recorded on the Respiratory Therapy Patient Record in the patient’s chart with each treatment.

2. Chest Physiotherapy
   a. Chest physiotherapy shall consist of maneuvers and tools designed to promote removal of secretions to include hydration of secretions, positioning, percussion, vibration, assisted cough techniques, breathing exercises, hyperinflation techniques and mechanical removal of secretions.
   b. Patients receiving chest physiotherapy shall be evaluated daily with documentation of effectiveness of therapy recorded on the Respiratory Therapy Patient Treatment Record.
   c. The date, time, mode of therapy or procedures performed, spontaneous tidal volume, frequency, blood pressure, pulse, arterial blood gas values, if available, sputum characteristics, breath sounds, and indications of effective cough shall be recorded on the Respiratory Therapy Patients Treatment Record.

3. Pulmonary Mechanics
   a. Ventilatory mechanics consisting of minute ventilation, vital capacity, tidal volume, negative inspiratory force and rapid shallow breathing index when ordered or indicated will be performed and recorded appropriately.
4. Airway Management
   a. Only staff who have demonstrated competency in placement of artificial airways will be
      allowed to insert any form of emergency artificial airway.
   b. Any procedure performed to establish, maintain, or discontinue artificial airway must be
      recorded in the Respiratory Therapy Patient Record of the patient’s chart.
   c. Tracheobronchial lavage is indicated only when mucous plugging and tenacious
      mucopurulent secretions are present.

5. Mechanical Ventilation
   a. Continuous mechanical ventilation, when ordered by a physician, will be initiated,
      maintained, and discontinued by the Respiratory Therapy Department.
   b. Aside from qualified physicians, only members of the Respiratory Therapy Staff will make
      adjustments to mechanical ventilators.
   c. When a physician wishes to alter a ventilator setting, he must write an order for the change.
      When there is an ambiguous order, the order will be clarified and adjusted to the desired
      settings.
   d. Ventilators shall be checked out thoroughly prior to use to assure proper function.
   e. Ventilators shall be equipped with appropriate functioning alarms
   f. Ventilators shall be documented every four to six hours.
   g. Ventilators shall have the patient circuit changed when it is visible soiled or as indicated.
   h. Ventilators should not be left on standby for longer than eight hours.
   i. The FIO2 can be analyzed with a suitable oxygen analyzer each shift and charted on the
      patient record on all patients receiving continuous mechanical ventilation.
   j. Mechanical failures of ventilators shall be reported as soon as possible.
   k. Ventilator Progress Records must be maintained on each patient. When the ventilator is
      discontinued the records will be placed in the patient’s record.
   l. Appropriate and complete ventilator settings should be charted on the 24-Hour Mechanical
      Ventilation Flowsheet.
   m. Procedures and treatments should be noted on the ventilator flowsheet as necessary.
   n. A daily charting summary of patient care and ventilation management should be charted in
      the Respiratory Therapy Patient Treatment Record.
   o. All order changes should be documented in red and circled on the Ventilator Progress
      Record.
   p. Cuff pressure, artificial airway size, airway placement marking, and circuitry change-out
      date should be charted at least once per shift.
   q. Static and dynamic compliance should be recorded with each ventilator monitor.

6. Medication
   a. The Respiratory Therapy Department administers medication from single patient unit dose
      vial whenever possible.
   b. When multi-dose vials are used, each vial will be used on one patient and discarded on or
      before the manufacturer’s recommended expiration date.
   c. Orders may be clarified by the supervisor with that physician prior to the drug being
      administered.
   d. Continuous nebulization of a drug should be administered in an appropriately monitored
      patient care setting as deemed necessary by the attending physician.

7. Transports
   a. The Respiratory Therapy Department is available to assist medically unstable patients who
      require oxygen during transports for therapeutic and diagnostic procedures. Respiratory
      Care will accompany all intensive care patients who are receiving conventional,
      unconventional, and noninvasive ventilation during therapeutic or diagnostic transports.
b. Each mechanically ventilated transported patient should have a qualified nurse and/or medical doctor present.

c. When a patient on the Respiratory Therapy Service must be moved to another facility in order to receive treatment not available here, the patient will be evaluated and a determination will be made that the transfer can be accomplished safely. If the ambulance service, etc., is not able to provide the patient with support equal to the care this service is providing, the patient's primary physician will be notified. If necessary, and with approval from Hospital Administration and the Respiratory Therapy Department's Administrative Staff, a therapist can accompany the patient in transfer.

H. Cardiopulmonary Resuscitation
1. Governing Authority
   Respiratory Care shall abide by the rules and regulations set forth by the Code Blue and Code 13 committees.

2. Employee Training
   Cardiopulmonary resuscitation will be administered using standards set by the American Heart Association. All members of the respiratory care patient care staff will maintain current Basic Life Support Healthcare Provider. Proof of certification will be maintained in the employees' departmental personnel file.

3. Emergency Equipment Inspection and Maintenance
   a. Airway Kits
      The airway kits are solely maintained by the respiratory care department. They are secured with numbered seals and are color coded to denote adult and pediatric contents. The expiration date on the airway kit denotes the six-month use-time of the laryngoscope batteries.

   b. Crash Carts
      Respiratory care cleans the carts and restocks the non-pharmaceutical items then sends the cart to pharmacy. After the carts are sealed by pharmacy, respiratory care stores the carts in a secured area until they are ready for use.

6. Documentation
   The Daily Emergency Equipment Records (see Appendix) will be housed in the respiratory care department. Stand-by carts in the department will be checked and recorded daily. A note will be written when a cart enters and leaves maintenance status.

Procedure for Inspecting Emergency Equipment:
1. Locate emergency cart.
2. Check that seals are intact on cart and airway kit(s).
3. Check that all drawers on cart are locked.
4. Check expiration dates on cart and airway kits.
5. Replace cart or airway kit if seals are broken, drawers are open, or when expired.
6. If the cart has a defibrillator you should
   a. Ensure unit is plugged into wall electrical unit
   b. Turn unit on
   c. Select test joule energy level
   d. Depress charge button
   e. Discharge unit
   f. Check to make sure the energy level is displayed when discharged
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8. Code Personnel Responsibilities
   a. Code Blue
      The pagers for Code Blue are designated Code Person-1 and Code Person-2. CP-1 is responsible for checking the emergency equipment in the respiratory care department at the beginning of the shift. CP-1 will also go immediately to the code after receiving a code alarm. CP-1 is responsible for charting and returning the Code Blue Record to the department. The person carrying CP-2 will be responsible for getting the back-up cart and defibrillator to the code. That person is also responsible for insuring that all equipment is gathered and replaced post event.

   b. Code Thirteen
      There are 2 pagers assigned to deliver emergency service during Code 13 situations. The designated first responder will go immediately to the code; the designated second respondent will get the back-up cart and defibrillator to the code.

   c. Supervisor
      The supervisor is scheduled to attend all code situations to assess the appropriateness and availability of equipment and personnel.

9. Electrocardiograms
   a. Electrocardiograms are performed by the respiratory care staff during code and emergency situations from 2200 to 0700 on weekdays and holidays and 2200 to 0900 on weekends. All other EKGs are performed by Heart Station personnel.

   b. The Department of Electrocardiology will provide all equipment and supplies for the EKGs and will maintain all of the equipment. The respiratory therapy staff will be familiar with this equipment and adhere to the policies and procedures concerning the operation of equipment as described in the EKG department’s operations manual.

I. Adverse Reactions
   In the event that an adverse reaction to therapy occurs, the therapist will stop therapy immediately and notify the supervisor on duty. The patient’s nurse and physician will be notified as soon as appropriate. The patient will be assessed to determine the severity of the adverse reaction. The supervisor or therapist will remain with the patient until the adverse response has resolved. Adverse reactions should be reported via the online Occurrence Report system.

J. Incomplete Orders
   In the event that orders for therapy are not complete, the Therapist/Technician will contact the Supervisor. The Supervisor will assess the patient and contact the primary or on-call service to complete the order.