

Respiratory Therapy Standards of Practice

[INDEX: \(click on a standard for a full explanation\).](#)

STANDARD I

[Referral](#)

Respiratory Therapists will treat patients who have been referred by a qualified medical practitioner.

STANDARD II

[Assessment and Planning](#)

Respiratory Therapists shall assess all referred patients prior to the initiation of treatment, understand the objective of the procedure and clarify with the physician if necessary. Respiratory Therapists shall provide a written treatment plan outlining modality of therapy and probable frequency of assessments as per patient classification protocol.

STANDARD III

[Intervention](#)

Respiratory Therapists will provide the planned modalities of treatment in accordance with departmental policies, procedures and practice insuring the diagnostic/therapeutic procedure is consistent and correct for the patient's condition.

STANDARD IV

[Evaluation](#)

Respiratory Therapists will evaluate the patient's progress towards the achievement of anticipated objectives and will maintain, revise or discontinue the treatment plan as required in consultation with the physician and in accordance with the department assessment protocol.

STANDARD V

[Communication](#)

Respiratory Therapists will maintain effective communications with the attending physician and appropriate health care personnel as to the patient's respiratory status and progress.

STANDARD VI

Refusal of Service

Respiratory Therapists shall notify and discuss with the responsible physician if the ordered procedure will be detrimental to the patient's condition.

STANDARD VII

Documentation

Respiratory Therapists will document initial assessments and patient response to therapy in the patient care record. Respiratory Therapists will document all pertinent information by exception to normal protocol on the patient care record.

STANDARD I

Referral

Respiratory Therapists will treat patients who have been referred by a qualified medical practitioner.

Criteria

1. Relevant Diagnosis Provided:

The diagnosis (primary or secondary) is clear, concise and relevant to the types of treatment provided by the therapist.

2. Details of Specific Treatments are provided:

The details of the requested treatments are provided in terms of:

- modality of treatment
 - Frequency of treatment (Q2H, Q4H, PRN, etc.)
 - type and dose of medication, as appropriate
 - Oxygen concentration or titration orders based on clinical data i.e. pulse oximetry range.
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STANDARD II

Assessment and Planning

Respiratory Therapists shall assess all referred patients prior to the initiation of treatment, understand the objective of the procedure and clarify with the physician if necessary. Respiratory Therapists shall provide a written treatment plan outlining modality of therapy and probable frequency of assessments as per patient classification protocol.

Characteristics

Therapists will understand the term "assess" to mean the following factors are evaluated.

1. A patient diagnosis and treatment objective which specifically relates to the prescribed therapy:

- Any concurrent treatments and/or tests being applied to the patient which could influence the effect of the proposed treatment.
- Any pertinent information concerning the patient's occupation, life style, and/or home environment.

2. Relevant Objective Findings:

Objective findings are those facts which have been obtained as a result of specific tests.

Examples include:

- laboratory results
- X-ray results
- arterial blood gases
- pulmonary function test

3. Relevant Subjective Findings:

Subjective findings are those impressions which have been obtained as results of physical assessment and discussion with the patient. Examples of such finds include:

- shape of chest
- color
- respiratory rate
- clubbing
- auscultation

4. Treatment Planning

If the treatment plan does not correspond to the initial orders provided by the referring physician there will be a notation in the progress notes indicating any deviation in treatment has been discussed, and approved by, the referring physician.

5. Adverse Reactions

Any adverse reactions are communicated to the physician and other appropriate members of the Health Care Team.

ASSESSMENT

1. The history is complete:

CRITERIA:

The information recorded within the history will be pertinent, concise, and legible. The following will be recorded:

- Illness and/or surgery
- Previous hospitalization for the diagnosis and/or treatment
- Any medications currently being taken by the patient
- Any concurrent treatments and/or tests being applied to the patient which could influence the effect of the proposed treatment.
- Any pertinent information concerning the patient's occupation, lifestyle and/or home environment.

2. Objective assessment findings are evaluated:

CRITERIA:

The findings or results obtained as a result of an objective assessment techniques.

- Laboratory findings - i.e. polycythemia
- X-ray results - consistent with pneumonia
- Arterial blood gases - i.e. Acid/base status
- Pulmonary function tests - i.e. consistent with obstructive lung disease.

3. Subjective assessment findings are evaluated:

CRITERIA:

The findings or results obtained as a result of subjective assessment techniques:

- Observation of the patient's general physical appearance.

- Auscultation of the chest.
- Respiratory rate.
- Shape of chest.
- Color of skin.

4. Therapists will understand the phrase "written treatment plan" to mean that the following factors are recorded:

- Date, time, respiratory diagnosis
 - Goals or objectives of the therapy
 - Effects of the therapy
 - Method or modality of the therapy
 - Statement as to the frequency of follow-up assessments as per the patient classification guidelines.
 - Any adverse reaction
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STANDARD III

Intervention

Respiratory Therapists will provide the planned modalities of treatment in accordance with departmental policies, procedures and practice insuring the diagnostic/therapeutic procedure is consistent and correct for the patient's condition.

Characteristics:

Therapists will understand the phrase "*in accordance with departmental policies, procedures and practices*" to mean that:

1. The performance of the treatment modalities is done in a manner which is recognized by the department as being the preferred or accepted method of application.
 2. The patient is informed as to the nature and purpose of the treatment.
 3. Problems or contraindications which arise during the intervention process are noted with appropriate communication to the referring physician.
 4. If the treatment regime is being transferred to another group for completion, this group receives explanations concerning the nature and aim of the treatment and explanations concerning any precautionary factors.
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STANDARD IV

Evaluation

Respiratory Therapists will evaluate the patient's progress towards the achievement of anticipated objectives and will maintain, revise or discontinue the treatment plan as required in consultation with the physician and in accordance with the department assessment protocol.

Characteristics:

Therapists will understand the phrase "*evaluate the patient's progress*" to mean:

That through the use of measurable objective and subjective parameters the therapist will evaluate the patient's degree of progress, or lack of progress, towards the planned aims and expected outcomes of treatment.

In cases where the treatment modalities significantly are altered from the initial physician's order, the therapist will provide a written not stating:

1. Reasons for the changes in treatment.
2. Results of discussions with the physician and authorization of the change.

Therapists will understand the phrase "*discontinue treatment*" to mean:

1. The expected outcomes of treatment have been achieved and the outlined problems have been resolved.
2. There is a reference to the fact that the referring physician is aware and approves the discontinuation of treatment.
3. Where applicable there is a note which outlines follow-up care.

Education:

The progress notes are legible, concise and pertinent. The date and time of each must be noted and properly signed by the therapist.

Criteria:

1. Through objective and subjective observations the progress notes indicate the patient's response to treatment and evaluate the patient's progress towards specific goals and expected outcomes.
 2. The progress and assessment notes are written in accordance with established procedures.
 3. Changes to the plan of treatment are noted and the physician is informed and authorizes such changes.
 4. Discontinuation of treatment plan when problems have been resolved and expected objectives have been obtained.
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STANDARD V

Communication

Respiratory Therapists will maintain effective communications with the attending physician and appropriate health care personnel as to the patient's respiratory status and progress.

Characteristics:

Therapists will understand the phrase "*maintain effective communication*" to mean:

1. That the referring physician and appropriate health care personnel are informed as to the patient's status and progress.
 2. That appropriate interdisciplinary discussions necessary to promote safe and effective patient care are initiated, attended and supported.
 3. That the continuity of patient care is maintained in cases where the therapist is relinquishing the treatment to another.
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STANDARD VI

Refusal of Service

Respiratory Therapists shall notify and discuss with the responsible physician if the ordered procedure will be detrimental to the patient's condition.

Characteristics:

1. The respiratory therapist will refuse to perform procedures that will be detrimental to the patient.
 2. Such refusal must be documented and reported to the senior therapist.
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STANDARD VII

Documentation

Respiratory Therapists will document initial assessments and patient response to therapy in the patient care record. Respiratory Therapists will document all pertinent information by exception to normal protocol on the patient care record.

Characteristics:

Therapists will understand the term "*document in the medical record*" to mean:

1. The respiratory therapy assessment is legible, concise and complete.
2. The initial physician's order is signed off by the therapist initiating treatment.
3. Therapists accepting verbal orders will ensure that such orders are written in the medical record.
4. Abbreviations used in charting will be in keeping with the acceptable hospital abbreviation list.
5. Additional charting is done by exception, i.e. any course of action differing from hospital/departmental protocol is documented.
6. Changes to therapy and/or requested order changes are noted on the chart.

Criteria:

Assessment documentation will include:

1. Date and Time: Year/Month/Day/Time
 2. Respiratory diagnosis
 3. Type of therapy
 4. Objective of therapy
 5. Effect of therapy
 6. Adverse reactions
 7. Instructions given to patient or patient's family
 8. Therapist's full signature
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