Respiratory Therapy Driven Protocols

Yes or No?

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A higher standard

RT driven protocols are changes made in therapy according to the patient’s clinical status ordered by respiratory therapist

The Therapist Protocols Cover:

- Patient assessment
- Chest PT
- Bronchial hygiene
- Aerosolized medications
- CPAP
- BiPAP
- Oxygen administration
- Ventilatory modes
- Pulse Oximetry
- Weaning procedures
Ideally Protocols Would Work Like This:

• Therapy adjusted more frequently in response to changes in patient’s status
• MD’s contacted for major changes not minor adjustments
  – eliminates nuisance calls
• Consistency of therapy maintained
  – non pulmonary MD’s employ proper care by requesting protocol therapy

Ideally Protocols Would Work Like This: (continued)

• RCP’s actively involved in achieving good outcomes
  – rather than performing rote tasks
• Raise the level of the profession
  – Attract and retain better educated and qualified practitioners

Why Don’t All MD’s Enthusiastically Accept and Implement Protocols?

• Don’t want treatment frequency adjusted
  – Q4 forever for everyone
• MD’s are not worried about nuisance calls
  – When they come they just double the frequency and add IPPB
Why Don’t All MD’s Enthusiastically Accept and Implement Protocols?
(continued)
• Non pulmonary MD’s don’t worry about Q4 forever
  – It works for everyone
  – No knowledge, no cares
• Many MD’s don’t believe RT’s are smart enough to know who needs what therapy
• Many MD’s love the year 1980, so why use 2014 wisdom

Why Do We Need Protocols?
• Misallocation of respiratory care
  – Care given but not needed
  – Care needed but not given
• Improve the quality of care
  – The right care at the right time
  – Decrease the length of stay
  – Improve outcomes
• Cut costs

Is Misallocation of Care Really a Problem?
• Oxygen Therapy
  – Ordered but not indicated in 28-72% of patients
  – Indicated in 8-21% of patients, but not ordered or ordered improperly
• Incentive Spirometry
  – Ordered but not indicated in 20-55% of patients
  – Indicated but not ordered in 4% of patients
• Bronchodilator Therapy
  – Ordered but not indicated in 12-50% of patients
  – Indicated but not ordered in 12% of patients
Is Misallocation of Care Really a Problem? (continued)

- Arterial Blood Gasses
  - Inappropriately ordered in 36-43% of patients
- IPPB
  - Still ordered frequently
- Bronchial Hygiene/Chest Physiotherapy
  - Ordered but not indicated in 32-61% of patients
  - Indicated but not ordered in 8% of patients

Today

- Inappropriate care is unacceptable in the current health care environment
- When protocols are used care improves

Examples

- Inappropriate ABG orders
  - When ordered by RT’s, only 3% inappropriate
  - All others, 45% inappropriate
- Current MDI use
  - When ordered by MD’s, 43-65% are ordered appropriately
  - When ordered by nurses, 4-83% are ordered appropriately
  - When ordered by RT’s, 85-100% are ordered appropriately
Protocol Based Respiratory Care Reduced Inappropriate Care By:

- 61% bronchial hygiene (Shapiro et al.)
- 59% aerosol medications (Zibrak et al.)
- 92% IPPB (Zibrak et al.)
- 55% Incentive Spirometry (Zibrak et al.)
- 72% ABG’s in ICU (Browning et al.)
- 48% basic care (Hart et al.)

Study Published in Chest by the ACCP

- Evaluation of the effectiveness of respiratory therapy driven protocols
  - 694 consecutive patients
  - Safe
  - Greater agreement with institutional treatment plans than with MD directed care
  - Overall rate of discordant respiratory care orders were significantly less than MD directed care

Final Thought

Respiratory Therapy Driven Protocols Enhance Professionalism