



Hospital Respiratory Therapy Daily Assessment

I. Purpose:

Respiratory Care Practitioners should use ongoing daily assessments and evaluations to assist physicians in providing optimal patient care therapies.

The following Respiratory Care protocol is designed to allow for the standardization of respiratory care procedures in accordance with national clinical practice guidelines. The protocols, policies and guidelines have been approved by the pulmonary medical staff and the Medical Executive Board.

III. Daily RCS Assessment:

At least twenty four (24) hours after a patient has been receiving ordered respiratory care procedure(s), the respiratory therapist may evaluate the patient to determine the effectiveness of the ordered therapy. Based on this assessment, if needed, the therapist may contact the ordering physician with recommended changes. All recommended changes shall be based on current national clinical practice guidelines and a thorough patient assessment.

Patients in strict airborne/contact isolation (such as suspected of having or infected with COVID-19, MERS-CoV, SARS, Ebola, etc...) should not be given aerosolized medications unless clinically indicated. Nebulized medications may be given to an appropriate patient if given in strict airborne/contact precautions. All ordered nebulizers will be assessed by a Registered Respiratory Therapist for appropriateness. If the patient has a history of COPD, asthma or is on a home nebulizer/inhaler regimen, continuation of the nebulizers/inhalers needs to be discussed with the ordering provider before starting or discontinuing. If the patient is in droplet isolation and contact precautions, nebulizers should be transitioned to either a metered-dose inhaler (MDI) with a spacer, dry powder inhaler (DPI), Respimat or Ellipta delivery method. The ordering provider and/or Registered Respiratory Therapist should encourage the patient to bring in their inhalers from home for use, secondary to the possibility of drug shortages.

Note: PAPR or fit-tested N-95 is recommended for aerosol-producing procedures and for 4 hours following the procedure. Shorter times may be considered if the room's air change hours have been confirmed and your facility Infection Preventionist has approved a shorter time frame.

The physician or mid-level should be notified immediately with all urgent concerns.

Recommendations may include:

1. The discontinuation of a treatment that is no longer appropriate (i.e. not tolerated, not effective, or no longer indicated based on the patient's current condition).
2. Changing the treatment frequency to optimize therapeutic effect.
3. Changing the method of delivery of a given medication (e.g. changing albuterol neb to albuterol MDI).
4. Changing or adding medications to optimize effect.

5. Recommendation of additional or other types of therapies to more effectively improve the patient's condition.

Procedure:

1. **If the patient is being seen by Pulmonary Medicine, all recommendations need to be reviewed with the pulmonary physician or mid-level. No changes can be made without their approval.**
2. All changes or recommendations MUST be relayed directly to the ordering physician or mid-level provider (PA or nurse practitioner) for that group. The Hospitalist group may be contacted if the ordering physician/group has signed off.
3. Before recommending any changes the therapist shall conduct the following:
 - Review of the patient's chart to include:
 - o H&P, CXR, labs, progress notes (patient notes), and other pertinent information.
 - o Past medical history including home medications and therapies.
 - Perform a direct patient assessment including:
 - o Pulmonary history, including current home medications, oxygen and CPAP usage
 - o breath sounds
 - o current oxygen requirements
 - o evaluation of response to current ordered therapy(ies)

IV. Medications

All respiratory medications should be reviewed, including: long acting bronchodilators, inhaled steroids, mucolytics or other airway maintenance medications.

When a bronchodilator therapy is indicated, but has not been ordered, albuterol will be the drug of choice unless the patient has had a previous adverse reaction to albuterol or is using another rapid acting bronchodilator such as levalbuterol at home.

If a patient receives inhaled medications at home, as the patient improves during their hospital stay, the goal should be to work on preparing the patient for discharge. This may include reviewing the home routine with the physician to help optimize medication delivery and compliance.

References:

- AARC Clinical Practice Guideline: Effectiveness of Nonpharmacologic Airway Clearance Therapies in Hospitalized Patients (2013)
- AARC Clinical Practice Guideline: Effectiveness of Pharmacologic Airway Clearance Therapies in Hospitalized Patients (2015)
- AARC Clinical Practice Guideline: Intermittent Positive Pressure Breathing – 2003 Revision & Update.
- AARC Clinical Practice Guideline: Nasotracheal Suctioning – 2004 Revision & Update
- AARC Position Statement: Inhaled Medication Administration Schedules. Revised 7/2011
- Ari A, Restrepo R. Aerosol Delivery Device Selection for Spontaneously Breathing Patients: 2012. *Respir Care* 2012;57(4):613-626.
- Davis M, Walsh B, Sitting S. AARC Clinical Practice Guideline: Blood Gas Analysis and Hemoximetry: 2013. *Respir Care* 2013;58(10):1694-1703.
- Proceedings from a special symposium on Respiratory Care Protocols: Benefits for Patients, Therapists and Hospitals. Presented at the 50th International Respiratory Congress of the American Association for Respiratory Care. December 2004.
- Stoller J. The effectiveness of respiratory care protocols. *Respir Care* 2004;49(7):761-765.

Please Note: This guideline was developed to assist in the delivery of care and is not intended to define the standard of care. Personnel may deviate from this guide to provide appropriate individualized care and treatment for each patient.

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