Providence HEALTH CARE	Department: **Respiratory Services**	Date Originated: September 1989 Date Reviewed/Revised: **March 2010**
POLICY & PROCEDURE	Topic: Emergency – Area Protocol & Respiratory Therapist Role & Responsibilities for the Emergency Department Number: B-00-16-12027	Related Links:

APPLICABLE SITES:

St. Paul's Hospital
Mount Saint Joseph Hospital

POLICY STATEMENT:

Respiratory Therapy services will be provided to the Emergency Departments of Mount Saint Joseph and St. Paul's Hospitals on a 24 hour basis.

The Respiratory Therapist will be responsible for assisting with the diagnosis, treatment, and care of all patients in the Emergency Department with respiratory or cardiorespiratory related compromise.

The constant attendance of a Respiratory Therapist for the unstable critically ill patient requiring resuscitation and/or ventilatory support is crucial to the safe and effective care of the patient. Once the patient is stabilized, the therapist may prioritize workload.

The Respiratory Therapist will provide all modalities of respiratory therapy to patients in the Emergency Department while adhering to existing protocols for patient assessment and care. The Therapist will ensure all relevant physician orders are followed, and correctly chart and document all therapeutic interventions.

PHYSICIAN ORDERS AND PLAN OF THERAPY:

The Respiratory Therapist will develop a plan of action for the patient based on their assessment in consultation with the Emergency physician.

The Respiratory Therapist will follow the established protocols or clinical pathways for providing respiratory therapy services.

Physician orders must be obtained for specific diagnostic and therapeutic interventions. The Respiratory Therapist must ensure that all verbal or telephone orders are transcribed on to the Physician's Order Sheet.

PATIENT ASSESSMENT:

The Respiratory Therapist will perform initial and ongoing assessments of patients presenting to the Emergency Department with respiratory or cardiorespiratory compromise.

The initial assessment performed by the Respiratory Therapist will include:

- Brief history as obtained from the patient
  - Home oxygen use
  - Previously diagnosed respiratory conditions and year of diagnosis
  - Home medications
  - Presenting symptoms and progression of illness
  - Smoking history
- Direct observation of patient condition
- Respiratory rate, pattern, and quality
- Oxygen requirements and pulse oximetry measurement
- Chest auscultation
- Baseline peak flow measurement (if indicated)
- Overall clinical evaluation

PROVISION OF THERAPY AND CLINICAL RESPONSIBILITIES:

Respiratory Therapists will provide the following clinical services within all areas of the Emergency Department:

1. Artificial Airway Management:

a. Assist with endotracheal intubation
b. Perform endotracheal intubation if certified under the guidelines of Policy RTD4188
c. Perform extubation
d. Insertion and maintenance of oral or nasal pharyngeal airways (shared with nursing)
e. Management of endotracheal tubes, tracheostomy tubes and tracheal stomas
f. Assist with obtaining a patent airway using difficult airway adjuncts
g. Assist with internal or external transports of artificial airway patients
h. Provide advanced ventilation modalities (i.e. HFOV as per critical care physician order only)

2. Initiation and Maintenance of Oxygen Therapy:

a. Oxygen therapy as per Providence Health Care Nursing Care Standard NCS6083
b. Low-flow oxygen therapy (shared with nursing)
c. High-flow oxygen therapy (all starts)
   - Ongoing assessment of patients requiring > 6 L/min oxygen
   - Assist with internal or external transports of high-flow FiO_2 > 0.50 patients
d. Heated humidity hypothermia unit (RTD5180)
e. FiO_2 0.95 for all patients with suspected exposure to carbon monoxide (CO)

3. Ventilatory Support:

a. Initiation, maintenance, and discontinuation of invasive mechanical ventilation
b. Regular monitoring and ongoing adjustment of ventilatory support
c. Initiation, maintenance, and discontinuation of non-invasive mechanical ventilation
d. Manual resuscitation
e. Assist with internal or external transports of ventilated patients

4. Initiation and Maintenance of Aerosol Therapy:

a. Initiation and maintenance of large volume bland aerosol therapy

5. Asthma Protocol and Pathway:

a. Initiation and maintenance of algorithm (shared with nursing)

6. Trauma Team and Cardiac Arrest Team:

a. Respond immediately to all trauma calls (code 99) and cardiac arrests (code 1111) within the department
b. Assist with cardio-pulmonary resuscitation

7. Bronchodilator Therapy:

a. Initiation and assessment of nebulized medications (shared with nursing)
b. Initiation and assessment of Metered Dose Inhaler medications with spacer (shared with nursing)
c. Metered dose inhaler, dry powder inhaler, and spacer instruction

8. Procedural Sedation:

a. Respiratory assessment and airway monitoring
b. Initiation and maintenance of oxygen therapy
c. Set-up and use of Capnostream20 capnography/oximetry monitor

9. Specialty Gas Administration:

a. Heliox Therapy (ventilated or non-ventilated)
b. Nitric Oxide delivery (as per critical care physician order only)

10. Diagnostic Procedures:

a. Arterial Blood Gas Punctures
b. Bedside Spirometry
   - may be deferred to Pulmonary Diagnostics if patient is to be admitted)
c. Peak flow rate measurements (shared with nursing)
d. Capnography (ventilated or procedural sedation patients only)
e. Oximetry (shared with nursing)
f. Home oxygen assessments

g. Overnight oximetry studies
h. Sputum collection and induction

DOCUMENTATION:

The Respiratory Therapist will ensure all relevant information is documented for both communication and legal purposes.

Documentation of Respiratory Therapy interventions and subsequent patient response will be done on a Critical Care Respiratory Therapy Flowsheet for all ventilated patients (invasive or non-invasive), those with an artificial airway in-situ, and anyone receiving specialty gas therapy (i.e. Heliox).

For all other patients any therapies and subsequent responses will be charted in the Nurses Notes section of the Emergency Nursing Assessment Flowsheet.

All medications administered by the Respiratory Therapist will be documented in the Medications section of the Emergency Nursing Assessment Flowsheet unless the patient has been admitted as an inpatient. Once the patient has been admitted all medications must be appropriately signed off on the Medication Administration Record.

COMMUNICATION:

The Respiratory Therapist responsible for the Emergency Department will carry a designated pager and be available to the department on a 24-hour basis at SPH, and during operational hours at MSJH.

At SPH the expectation is that the therapist will spend the majority of their time within the Emergency Department. If leaving for extended periods (such as a transport or to assist heavy workload in other areas) the therapist should communicate this to the CNL and/or UC, or arrange for cross-coverage when appropriate.

At MSJH a periodic walk-through of the department should be undertaken.

End-of-shift report must be provided to the oncoming therapist, and should include relevant information about current or expected patients, as well as pertinent equipment or supply concerns (i.e. equipment in SPD for reprocessing).

A full patient history report will be provided to the therapist accepting care for a patient that has been transferred out of the Emergency Department.

EQUIPMENT AND SAFETY CHECKS:

The Respiratory Therapist will check daily the operational capabilities of the required respiratory equipment and for the presence of adequate supplies as per the Emergency Trauma Respiratory Checklist, and initial the checklist log as having been completed.

At St. Paul's Hospital, the therapist covering the Emergency Department will also be responsible for completing the daily equipment and safety check in the NICU.