



NORTH CAROLINA RESPIRATORY CARE BOARD
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POSITION STATEMENT

RESPIRATORY CARE STAFFING LEVELS

This Position Statement illuminates an area of concern by the North Carolina Respiratory Care Board about Respiratory Care staffing levels. The Board is issuing this position statement to explain its interpretation of the Respiratory Care Practice Act ("the Act") and the Board's Rules, as the Act and Rules related to the establishment of respiratory staffing levels. The Board issued a position statement addressing this issue on January 12, 2012, after receiving a request for Declaratory Ruling from the North Carolina Respiratory Care Managers group. After the Board determined that the members of the Managers Group were not aggrieved by the provisions of the Act and the Board's Rules that were cited in the request, the Board declined to issue a declaratory ruling and issued the position statement instead. Because of issuing this new Position Statement on this issue, the Board is also withdrawing the prior position statement issued in 2012.

This Position Statement provides general guidance to the Board's licensees and to other health providers. In issuing this Position Statement, the Board presents general principles that it believes should be considered in establishing Respiratory Care staffing levels. The Board is not determining that any individual or organization has violated the Act or the Board's Rules or that a particular course of action violates the Act or the Board's Rules. Therefore, the issuance of this Position Statement does not constitute an adverse determination affecting any individual or organization. The Board will not initiate disciplinary action against a licensee or other action against organizations or unlicensed individuals, based solely on an alleged violation of the principles described in this Position Statement. However, the Board will follow up if it receives specific information about a particular adverse event or a particular course of conduct affecting Respiratory Care staffing levels after due consideration and assessment of the specific information that it has received.

This position statement will be posted on the Board's website. Still, as it exercises its statutory responsibilities, the Board reserves the right to change or supplement this position statement based on future developments or situations that come to its attention.

BACKGROUND ON THE MATTERS AT ISSUE

This prior position statement was issued in 2012 in response to a concern raised by various Respiratory Care Practitioners, including the North Carolina Respiratory Care Managers group. The concern, as it was expressed to the Board, is that organizations were applying unrealistic or inadequate staffing measurement standards to project the number of full-time equivalents

(FTE) staff that would be needed to provide respiratory services to patients, in some cases based on recommendations from outside consultants to the organizations.

In particular, and based on information furnished to the Board, some organizations were setting their respiratory staff levels by: (1) relying exclusively on billable procedures based upon Current Procedural Terminology (CPT) codes or other standard billing protocols; (2) using standardized models that are derived solely from general data such as patient days, or average daily census; or (3) applying industry-wide benchmarking criteria.

Initially, the North Carolina Respiratory Care Managers Group (“the Managers Group”) presented a Request for Declaratory Ruling to the Board on this issue. Members of the Managers Group supervise their staff and ensure that the persons who act under their supervision provide appropriate Respiratory Care services. Therefore, the Managers Group was concerned that they might be affected by the Board’s application of NC. Gen. Stat. § 90-659(a)(1)(d), to the staffing levels in the institutions where the members work and supervise others. That portion of the Act prohibits “health care practices that are determined to be hazardous to public health, safety, or welfare.” There also is a related provision in the Board’s rules at 21 NCAC 61 .0307(10), which states that unprofessional conduct is a basis for license denial or discipline.

The Managers Group requested a declaratory ruling that addressed and defined the standards, metrics, and staffing systems that may be used to set staffing levels safely and cost-effectively in hospital Respiratory Care Departments in this state. As noted above, the Board declined to issue the ruling after it determined that the members of the Managers Group were not aggrieved by the application of the cited portions of the Act or the Board’s Rules. However, the Board determined that the Managers Group had raised a significant issue that merited attention in a Position Statement based on the information submitted or available to it.

Detailed information on the staffing level issue’s scope and depth was originally obtained in a state-wide survey of Respiratory Care Department Managers conducted in June of 2011. This study sought to determine the current staffing metrics and patterns in use and derive some general information about the effects of the resulting staffing levels on patient care. Thirty-five Respiratory Care Managers from the approximately 150 NC Hospitals in the state responded to the survey, constituting approximately a 23% response rate. The survey results are described in detail in Appendix A. In general, the results showed that the Respiratory Care Managers responding to the survey had significant concerns about staffing levels.

The information obtained in this 2011 survey, though admittedly incomplete, presented a very serious and significant issue that can directly impact patient safety. Therefore, in 2013 the Board issued a Position Statement on staffing care levels based on the findings of the survey and the recommendations in the 2012 AARC White Paper titled, *Best Practices in Respiratory Care Productivity and Staffing*. In 2020 and 2021, the COVID-19 Pandemic required facilities throughout North Carolina to address significant staffing shortages. The Board responded to many requests for clarification on staffing issues using previous positions taken by the Board. As the Pandemic continued into 2021 with the rising cases of the Delta Variant, staffing shortages became more significant. For this reason, the Board determined that it should revise

and update this Position Statement to identify the specific behavioral issues documented by the Board and to address the staffing shortages, roles, and responsibilities of RESPIRATORY CARE PRACTITIONERS and Respiratory Care Managers and Directors¹.

The issues identified in the survey of the Managers Group became even more salient when the COVID-19 Pandemic was declared as a National Emergency by the President of the United States and a North Carolina State Emergency by Governor Cooper. The Board responded to multiple requests by managers, administrators, and agencies regarding guidance on impending staff shortages since March 18, 2020. The immediate response to mitigate staffing shortages included approving comprehensive emergency rule waivers on March 18, 2020. On March 20, 2020, the rules were approved by the Rules Codifier for the NC Rules Commission and took effect on March 30, 2020. The rules were designed to reduce the time for licensing and alleviate the continuing education requirements during the Pandemic. As a result, licensing time was reduced to 2 days for out-of-state applicants holding an active license or for those qualifying for reciprocity. In January of 2021, the Board voted to adopt the waivers as permanent rules for the full duration of the National Emergency Declaration and future emergencies. The permanent Board Rule 21 NCAC 61 .0901, entitled RULE WAIVERS, went into effect on June 1, 2021. While the initial staffing shortages were mitigated, the second and third waves of the Pandemic proved more challenging for managers. Behavioral issues began to emerge that resulted in actions against licensees. Therefore, the Board determined that the issues identified merited a more comprehensive response.

POSITION STATEMENT

A. Respiratory Staffing Levels Can Have a Direct Impact on Patient Safety.

The Board does not have direct authority or oversight over the conduct of institutions that have Respiratory Departments and their staffing levels, including patient-to-practitioner ratios or ventilator-to-practitioner ratios. However, the Board has been granted explicit statutory authority over the practice of Respiratory Care. This grant of authority is based on the fundamental premise enunciated by the General Assembly in the Act, that “the practice of respiratory care in the State of North Carolina affects the public health, safety, and welfare ...” NC. Gen. Stat. § 90-647.

Further, there is broad recognition in the health care industry that staffing levels are a compliance issue for the institutions that offer Respiratory Care. In the Conditions of Participation for Hospitals, issued by the Centers for Medicare and Medicaid Services (CMS), there is the requirement for Respiratory Care Services that “the hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirement applies if the hospital provides respiratory care service... “ the CODE OF FEDERAL REGULATIONS 42 CFR § 482.57 states: *“there must be adequate numbers of Respiratory Therapists and other personnel who meet the qualifications specified by Medical Staff, consistent with State law.”* This provision in the federal rules is paralleled by the provisions in a rule adopted by the NC

¹ The use of the terms Managers and Directors is intended to include all persons responsible for managing the delivery of Respiratory Care in an organization, whether that is their only responsibility or is one of several responsibilities within the organization.

Department of Health and Human Services (NCDHHS), 10A NCAC 13B .4402 (a) and (b), which states *“staffing numbers shall be determined by the types and complexities of the services offered....the director of the service shall provide for the availability of trained respiratory technicians, Certified Respiratory Therapy Technicians, registry eligible or Registered Respiratory Therapist needed for the scope of services offered.”*

The number and qualifications of the Respiratory Care staff who work at an organization at any given time certainly can directly and substantially impact the quality of Respiratory Care provided. Under its statutory authority and the legislative mandate, the Board has adopted rules that address the licensees' qualifications and behavior. Those rules forbid the assumption, or the delegation, of duties for which a Respiratory Care Practitioner is not well qualified, as stated in 21 NCAC 61 .0307 (13). The sheer number of Respiratory Care Practitioners who are available to provide services can profoundly and directly impact the quality of care. Therefore, in adopting this position statement relating to Respiratory Care staffing levels, the Board is acting well within its statutory authority.

B. Any Metric, Model, or System Used to Define Respiratory Staffing Levels Should Recognize and Account Appropriately for All the Activities Required of a Respiratory Care Practitioner During the Relevant Period.

Measurements that forecast the levels of respiratory staffing required should recognize and account for all the activities in which each Respiratory Care Practitioner (RCP) can reasonably be expected to be engaged. The information submitted to the Board indicates that some organizations may engage in one or more of the following approaches to establish Respiratory Care Staffing levels:

- Relying solely on CPT codes or other standards that only define activities that may be billed to a patient or third-party payor;
- Relying on other internal measures that do not embrace all of the activities required of Respiratory Care Practitioners during a particular period;
- Relying on general, undifferentiated measures such as procedure counts fail to include the varying time required to perform different procedures. One procedure, such as measuring peak expiratory flow rate, may take 5 minutes to perform, whereas another procedure, such as bronchoscopy assistance, may take 70 minutes to perform;
- Limiting the number of repetitive actions per patient in a unit of time to a level that does not accurately reflect a realistic level of involvement;
- Including fixed time spent for management, supervision, education, meetings, research, and support activities in variable, direct patient care productivity measures; and
- Setting staffing levels by benchmarking with other institutions that have any of the preceding approaches or are using inaccurate data from external proprietary consulting companies which have not been validated or without appropriately accounting for

differences in department services or patient acuity levels. Reliance on another institution's faulty methodology just compounds and perpetuates the erroneous assumptions.

Any of the approaches listed above can lead to an insufficient level of Respiratory Care staffing or inappropriate use and allocation of staff resources. For instance: An exclusive focus on CPT codes or other standards that only defines activities that may be billed can lead to the omission of a large number of non-billed activities from the total Respiratory Care staff time that may be required, including each of the following, among others:

- Adult Transcutaneous monitoring during High-Frequency Oscillatory Ventilation;
- Airway Management Procedures (suctioning, monitoring cuff pressure, manipulation of specialty airways, and application of airway attachments such as speaking valves;
- Apnea Testing for Brain Death;
- Arterial Line Insertion;
- Assessment/Screening Patients for Obstructive Sleep Apnea;
- Assessments of Patients;
- Attendance at High-Risk C Sections and Deliveries;
- Cardioversion Monitoring of the Patient;
- Code Blue Responses for Cardio-Pulmonary Emergencies;
- Conscious Sedation Monitoring;
- Documentation, Completion, and Processing Physician Orders;
- Processing Patient Charges;
- Endotracheal Tube Repositioning and Securing;
- Extubations;
- Heliox Administration;
- Inpatient Sleep Apnea Monitoring;
- Lung Recruitment Maneuvers;
- Nitric Oxide Administration;
- Participation in Multi-Disciplinary Critical Care Rounds;
- Patient and Family Education;
- Patient Self-Management Programs (examples Include Asthma and COPD Education);
- Patient Transports Requiring Mechanical Ventilation or Airway Care;
- Rapid Response Team Participation;
- Respiratory Care Consultations;
- Setup and Monitoring of Patient Monitoring Devices;
- Setup and Monitoring of Oxygen Delivery Devices;
- Smoking Cessation Consultation and Education;
- Spontaneous Breathing Trials;
- Tracheotomy or Bronchoscopy Assistance;
- Ventilator Management and Weaning.

Similarly, relying on internal measures, such as Total Patient Days, Average Daily Census, Adjusted Discharges per Patient Day, and Nursing hours per patient day, none of which accounts for all of the activities required of Respiratory Care Practitioners during a particular period can lead to the omission of important functions from staff-level planning.

The use of productivity measures that involve comparisons to other organizations or benchmarking an organization's staffing to industry-wide data that do not accurately and fully account for the activities required for a particular patient population in an individual organization can lead to the omission of important functions from planning for staff levels.

The use of inappropriate metrics or inaccurate benchmarking or comparative data can result in adverse events and outcomes, including a tendency to emphasize procedures that can be billed, spending less time on non-billable procedures, reduced levels of service, the provision of different standards of care delivered to different areas of the hospital, or a tendency to provide concurrent therapy to make up for the lost time. Also, as this Position Statement details below, using these approaches can have a significant negative impact on the Respiratory Care Staff, resulting in a negative impact on staff morale, increased staff turnover, and increased staff stress levels due to staff being prevented from providing the proper patient care. Therefore, using inappropriately narrow measures or inaccurate Respiratory Care performance benchmarks can seriously impact the quality of Respiratory Care and thereby affect "the public health, safety, and welfare ..." NC. Gen. Stat. § 90-647.

The Board has reviewed and considered the Position Statement addressing *Best Practices in Respiratory Care Productivity and Staffing* in 2013, issued by the American Association for Respiratory Care in July of 2012 and revised in 2015. The Board endorses each of the following basic principles, which are adapted from that Position Statement:

1. Any metric, model, or system used to define respiratory staffing levels within institutions should recognize and account for all the activities required of a Respiratory Care Department in that institution. The level, scope, and frequency of these activities vary greatly among institutions, and therefore must be determined on a case-by-case basis and approved by the medical staff and administration at the individual facilities.
2. Because of the varying time required to perform different Respiratory Care procedures, systems to determine staffing should be based upon statistically valid activity time standards for all the services provided by a department.
3. Because of the significant variability in the nature and types of care rendered in treating patients in need of respiratory services, unweighted metrics such as patient days, etc., should not be used to determine respiratory therapist staffing levels.
4. Use of unweighted workload metrics is likely to lead to the establishment of inaccurate and insufficient staffing requirements. An exclusive focus on CPT-coded procedures to determine staffing levels or other standards based exclusively on billable activities can lead to the omission of a significant number of non-billed activities from the estimated Respiratory Care workload and result in underestimating the number of staff needed.
5. Adequate staffing levels help ensure that a consistent standard of Respiratory Care is provided throughout the facility and decrease the potential for error and harm by providing

respiratory therapists adequate time to perform required functions and can contribute to greater levels of patient satisfaction.

6. Health care reforms and programs may provide new opportunities in which value metrics can be applied. In such cases, Respiratory Care resources can be justified, and productivity assessed through value outcomes, including quality indicators, cost reductions, customer satisfaction, penalty reduction, decreased readmissions, and other metrics that can be linked directly to the activities of Respiratory Therapist.
7. Understaffing Respiratory Care services places patients at risk for unsafe incidents, missed treatments, and delays in medication delivery and increases the liability risk for the facilities.
8. Adverse Events directly related to inadequate staffing must be reported to the North Carolina Division of Health Service Regulation (DHSR) and the Centers for Medicare and Medicaid Services (CMS).

In addition, the Board also recommends the following additional criteria for determining staffing levels:

1) **Effective staffing systems apply well-documented Relative Value Units.**

- Because of varying time allotments required to perform different Respiratory Care procedures, the Respiratory Care staffing productivity measures used to establish staffing levels should be based upon Relative Value Units (RVU's) for all the services a particular department provides. Relative Value Units have been widely recognized as appropriate measures and adopted by the CMS for physician reimbursement.¹ Other metrics have been shown to correlate poorly with Relative Value Units and should not be used to determine staffing and productivity.²
- National RVU time standards, such as the system in the American Association for Respiratory Care Uniform Reporting Manual³, should be utilized to construct a staffing system.
- Since Respiratory Care is “seasonal” and procedure volumes historically increase during the cold and flu season between December and April, historical RVU data from these high-volume periods should be used to project additional staffing required for these and other high intensity operating periods.

2) **Effective staffing systems account for all expected tasks and activities.**

- The system should account for non-billable procedures and tasks, in addition to those that are billable.
- It has been documented in the literature that unscheduled Respiratory Care activities, including such tasks as Emergency Department procedures, patient transports, and rapid response calls, may account for up to 40% of the workload.⁴ Staffing levels

should account for this unpredictable part of the workload based upon historical data and work rate. Failure to include unscheduled procedures in staffing projections results in mathematically impossible workloads and understaffing.⁴

C. Any Data, Model, or system used to Project Required Levels of Respiratory Staffing by non-licensed Respiratory Care Practitioners that impact staffing levels may constitute practicing Respiratory Care.

In the Board's prior Position Statement entitled, "Respiratory Care Management," the Board stated:

The individual responsible for direct management of Respiratory Care Services is responsible for day-to-day operations related to patient care issues which include: Determines staffing needs and schedules assigned staff accordingly. The Position Statement further states: Individuals supervising or managing inpatient care environments must meet the same rigorous standards of professional competency to ensure the safe delivery of care. Respiratory Care Services are such that the public is at risk of injury, and health care institutions are at risk of liability when respiratory therapy is provided by inadequately educated and unqualified health care providers rather than by practitioners appropriately educated in the specialty of Respiratory Care.

Individuals and organizations that provide metrics, comparative data, benchmarking data, and budget salary dollars for Respiratory Care staffing levels directly impact the staffing of North Carolina hospital Respiratory Care departments. Any determination of Respiratory Care staffing levels that fails to account for the full spectrum of activities that will be required of Respiratory Care Practitioners or which simply imposes a general comparative or benchmarking staffing model that is not based on the actual, real-time experience of the institution in question, essentially fails to account for the complete range of actions and activities that a Respiratory Care Practitioner will routinely perform. In those circumstances, the individuals or organizations presenting or recommending these incomplete staffing models effectively decide that a portion of the spectrum of Respiratory Care activities need not be provided. Any such determination of Respiratory Care staffing levels constitutes an implicit determination that all of the required, but unaccounted for, Respiratory Care activities are unnecessary. Because the staffing level will be insufficient to provide the unaccounted activities for patients, the Respiratory Care Practitioners may be forced to engage in unacceptable conduct, such as concurrent therapy.

Thus, individuals and organizations who recommend or establish staffing levels without accounting for the full spectrum of Respiratory Care activities are making judgments that will directly impact the resources available to provide the full scope of Respiratory Care that patients need in a given period. Therefore, in establishing staffing levels based on the performance of only an incomplete picture may be determined to be engaging in the Practice of Respiratory Care, which requires a license from this Board. Practicing Respiratory Care in North Carolina without a license is a Class 1 Misdemeanor.

D. Short Staffing and Extended Work Hours pose considerable challenges for Respiratory Care managers/directors and for the Practitioners whom they supervise.

RCPs and RCP managers/directors are accountable for the provision of safe Respiratory care to their patients. The Respiratory Care Practice Act and the Board's rules mandate that RCPs accept assignments they are safe and competent to perform. The Respiratory Care Practice Act and the Board's rules also mandate that Respiratory Care managers/directors remain available for direct participation in Respiratory Care; delegate responsibility or assign Respiratory care functions to qualified personnel and retain accountability for Respiratory Care given by all personnel to whom that care is assigned and delegated. During periods of understaffing or limited numbers of well-qualified staff, Respiratory Care managers/directors and Respiratory Care staff must work together to provide safe care to all patients in a manner consistent with Respiratory Care law and rules. Clear communication is essential to arrive at solutions that best focus on patient care needs without compromising patient safety or an RCP's license. Concerns about patient Abandonment and Neglect are often related to these challenges and situations of Emergency Preparedness.⁵ Many issues have been identified by the Board that may impact care. The Board is addressing four of those issues in this Position Statement to provide background.:

ISSUE # 1: EXTENDED WORK HOURS

The Board receives frequent inquiries concerning the number of hours an RCP may work during a 24- hour period and still be able to provide safe and effective patient care. Although the Board regulates only the practice of the individual RCPs and has no jurisdiction over employer/employee issues or facility policies such as work hours, it is appropriate for the Board to provide guidance in addressing this concern as part of this Position Statement. .⁵

RESPONSIBILITY OF THE INDIVIDUAL RESPIRATORY CARE PRACTITIONER:

1. Inherent in the mandate to accept only those assignments that the RCP is safe and competent to perform is the expectation that the RCP will not accept any assignment for which they may be unsafe due to lack of sleep, fatigue, or prolonged work hours.
2. It is imperative for RCPs and Respiratory Care managers/directors to consider the evidence that extended work hours may adversely impact patient safety and carefully consider safety to practice before giving or accepting an assignment.
3. Cumulative work hours resulting from multiple work commitments or from scheduled work hours combined with actual hours worked while fulfilling on-call assignments must be considered carefully by RCPs and Respiratory Care managers/directors.
4. Based on existing evidence, caution should be exercised whenever an assignment is expected to exceed 12 hours in a 24-hour period or 60 hours in a 7-day period.

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RESPONSIBILITY OF THE RESPIRATORY CARE MANAGER-DIRECTOR:

During periods of understaffing, the Respiratory Care manager/director may have to reassign staff to different patient care areas and approve extended tours of duty (e.g., double shifts) for RCPs volunteering or agreeing to work extra hours/shifts.⁵

1. The Respiratory Care manager/director is responsible and accountable for ensuring adequate Respiratory Care resources are available.
2. If an RCP has agreed to extend their hours of duty due to short staffing but has informed the Respiratory Care manager/director of a limit to the extra hours they will work, the Respiratory Care manager/director is responsible for arranging for an RCP who can accept the report and responsibility for the patients from the overtime RCP at the agreed-upon time.
3. If a replacement RCP cannot be found, the Respiratory Care manager/director is responsible for providing the coverage.
4. Failure of the Respiratory Care manager/director to respond to calls from the RCP on duty does not relieve them of responsibility for providing coverage or accountability for the care of the patients.
5. Respiratory Care laws and rules require that the Respiratory Care manager/director assess the capabilities and competence of any RCP before assigning patient care responsibilities to them. When the Respiratory Care manager/director has or should have reason to believe that the RCP is impaired due to physical (including illness, fatigue, and sleep deprivation) or psychological conditions, the assignment of extended tours of duty, mandated overtime, or scheduled work hours in combination with actual hours worked while fulfilling “on-call” assignments is not appropriate.⁵

ISSUE #2: INADEQUATE STAFFING

When an RCP comes on duty to find that the mix or number of staff is not adequate to meet the Respiratory Care needs of the patients, the RCP should contact the immediate supervisor before accepting the assignment to report the unsafe situation and should ask for assistance in planning care based on the available resources within the organization.⁵ Such assistance may include, but is not limited to:

1. Acquiring additional or a different mix of staff;
2. Negotiating “periodic” assistance from the immediate supervisor or another staff member for delivery of specific patient care activities;

3. Prioritizing the patient care activities that will be delivered during that shift or tour of duty; and
4. Notifying other health care providers who are on staff in the same health care organization and who have shared responsibility for the patients who are receiving Respiratory Care Services from the RCP about any limitations in providing optimal care during periods of understaffing; and
5. Documenting the care delivered to the patients accurately. ⁵

RESPONSIBILITY OF THE INDIVIDUAL RESPIRATORY CARE PRACTITIONER:

1. The RCP is accountable for the care that they provide to the patient and all Respiratory Care that the RCP may delegate or assign to other staff members. ⁵
2. Although it may be impossible to deliver the type of Respiratory Care that normally would be provided with a full complement and appropriate mix of staff, certain activities must be carried out regardless of staffing. These activities include:
 - a) Accurately administering therapies and implementing critical medical treatment regimens;
 - b) Monitoring patients' responses to medical and Respiratory Care interventions consistent with each patient's health care problem(s);
 - c) Notifying the physician or other responsible healthcare provider of deteriorating or unexpected changes in a patient's status; and
 - d) Documenting the care delivered to the patients accurately. ⁵

ISSUE # 3: PATIENT ABANDONMENT

Patient abandonment can only occur after the RCP has come on duty for the shift, received a report including the status and needs of assigned patients and other assigned responsibilities, and accepted the designated patient care assignments. There is no rote answer to the question, "When does the RCP's duty to a patient begin?" The focus in Respiratory Care law and rules is on the relationship and responsibility of the RCP to the patient, not to the employer or employment setting. Suppose the RCP does not accept the assignment. In that case, the RCP's relationship and responsibility to and for the patient are not established. ⁵

RESPONSIBILITY OF THE INDIVIDUAL RESPIRATORY CARE PRACTITIONER:

1. Once the RCP has accepted an assignment; the RCP remains responsible and accountable for patient care and safety until another qualified RCP or other qualified person has accepted responsibility for that patient.
 - a. This transfer of responsibility includes a report of patient status. The timing and procedure for this transfer may vary based on work setting and patient care needs but generally occurs at the end of a scheduled shift; or when an RCP leaves a work area for a limited purpose (e.g., to transport another patient or take a break); or when a home care RCP is not making a scheduled visit.
 - b. In-home care settings, this transfer of responsibility may include release to patient self-care or transfer of care to an authorized/approved/trained caregiver as provided in the patient plan of care.
2. A violation of Respiratory Care law and rules may result from abandoning an assigned patient in need of Respiratory Care without planning to continue equivalent care. Adequate notification of the arrangements made for the equivalent patient care and negotiation for such continuation should include the immediate supervisor/manager.
3. However, when an RCP refuses to remain on duty for an extra shift or partial shift beyond their established schedule, it is not considered abandonment when the RCP leaves at the end of the regular shift, providing they have appropriately reported off patient status to another RCP or authorized/approved/trained caregiver and has given management notice that the RCP is leaving.
4. On-call assignments require the availability and response of the RCP within the employing organization's guidelines. Failure of an RCP to respond and report for on-call patient care responsibilities without adequate notification to the immediate supervisor, or failure of an on-call Respiratory Care supervisor/manager/director to respond to a call from patient care staff, may result in a violation of Respiratory Care law and rules for abandonment.
5. It is not considered abandonment under Board of Respiratory Care regulations if an RCP is "no call, no show"; or resigns without fulfilling a previously posted work schedule or reports for work but then declines an assignment. ⁵

ISSUE #4: PATIENT NEGLIGENCE

Patient neglect occurs when an RCP fails to provide patient care as ordered and indicated by patient status. Neglect may include, but is not limited to, failure to assess/evaluate patients; failure to maintain standards of care; failure to administer ordered medication or treatments; failure to perform cardio-respiratory resuscitation (CPR) unless a do not resuscitate order is in place; failure to make scheduled home care visits; and sleeping while on duty. ⁵

RESPONSIBILITY OF THE INDIVIDUAL RESPIRATORY CARE PRACTITIONER:

1. Once an RCP has accepted an assignment, the RCP remains responsible and accountable for comprehensive (RC) or focused patient care and safety based on Respiratory Care scope of practice, standards of Respiratory Care practice, and the employing organization's policies and procedures.
2. A violation of Respiratory Care law and rules may result from neglecting a patient who needs Respiratory Care. ⁵

CONCLUSION

The Board urges organizations that offer Respiratory Care services to work closely with the Respiratory Care Managers and Practitioners to develop comprehensive and realistic metrics, staffing models, and benchmarks that are evidence-based, data-driven, and capture the full range of activities required of Respiratory Care Practitioners; so that staffing is set at levels which can provide consistent, safe, cost-effective, and high-quality care.

It is unethical for a licensee of this Board to recommend staffing metrics or staffing patterns that will clearly affect understaffing a Respiratory Care Department. Unethical conduct by a Licensee is subject to disciplinary action by the Board.

The Board recommends the principles outlined in this document to establish safe and effective staffing levels in Respiratory Care Departments. Specific conduct brought to the Board's attention and determined to constitute the unlicensed practice of Respiratory Care is subject to remedies in the Act.

Approved this 14th day of October 2021

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APPENDIX A: SURVEY RESULTS

1. Approximately 30% of hospital Respiratory Care Departments are chronically understaffed. (Defined as more than two FTE understaffed for more than 30 days).
2. Approximately 75% of hospital RT departments are using metrics that specifically are recommended to NOT be used by the national professional association (AARC) because they underestimate staffing levels required for safe services.
3. 100% of the Respiratory Care Management felt that the determination of safe staffing levels requires professional judgment to ensure patient safety and falls within the scope of practice for Respiratory Care.
4. More than 50% of the Respiratory Care Management rated the benchmarking/comparative data provided by external consultants as “poor” or “extremely poor” because of inaccuracies of the data provided by the proprietary companies.
5. Multiple patient safety issues were cited by Respiratory Care Management due to understaffing because of erroneous data provided by consultants, including:
 - a. Missed medication treatments. (# 1 issue based upon responses)
 - b. Delayed medication treatments. (#2 issue based upon responses)
 - c. Delays in responding to emergency code situations and rapid response calls.
 - d. Patients who experienced respiratory distress.
 - e. Staff practicing concurrent therapy. (#3 issue based upon responses)
 - f. Increased incidence of Ventilator-Associated Pneumonia.
 - g. Decreased handwashing compliance.
 - h. Increased pressure ulcers due to tight straps from masks.
 - i. Multiple managers reported that the number of ventilator patients to therapists during the busy season (December through April) exceeded what was mathematically possible for one person to accomplish, based on 2004 AARC URM time standards.