وزارة الصحة

سياسات واجراءات

اسم السياسة: Respiratory Therapy Scope Of Service	رمز السياسة: MOH POL HOS RT 09
عدد الصفحات: 4 صفحات	الطبعة: الأولى

الوحدة التنظيمية: مديرية التطوير المؤسسي وضبط الجودة		
الجهة المعنية بتنفيذ السياسة: شعبة المعالجة التنفسية		
الاعداد: لجنة تطوير واستحداث وحدات المعالجة التنفسية في مستشفيات وزارة الصحة	التوقيع: التوقيع: التوقيع: التوقيع: التوقيع: التوقيع: التوقيع:	تاريخ الاعداد: ٢٠٢٤/٨/
المراجعة: قسم إدارة الجودة / شعبة سلامة المرضى	التوقيع: Abdullah	تاريخ المراجعة: ٢٠٢٤/٨/
التدقيق من ناحية ضبط الجودة: مدير مديرية التطوير المؤسسي وضبط الجودة	التوقيع:	تاريخ تدقيق ضبط الجودة: ٢٠٢٤/١١/
الاعتماد: عطوفة الأمين العام للشؤون الإدارية والفنية	التوقيع:	تاريخ الاعتماد: ٢٠٢٤/١١/٢٧

وزارة الصحة
مديرية التطوير المؤسسي و ضبط الجودة
السياسات و الإجراءات
Policies & Procedures
ختم الاعتماد
معتمدة
Approved

تتم مراجعة السياسة كل سنتين على الأقل من تاريخ اعتماد آخر طبعة :

رقم الطبعة	تاريخ الاعتماد	مبررات مراجعة السياسة

ختم النسخة الاصلية

MASTER COPY

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1- Policy:

1.1 Respiratory therapists work together with physicians, nurses and other allied health care professionals to provide complete and optimal respiratory care.

1.2 All respiratory therapists (RT's) should maintain knowledge of and follow the written protocols, policies and procedures for providing excellent RT care.

2- Purpose:

To establish and define the roles and responsibilities of respiratory therapists at hospital in the aim of providing the most optimal and effective respiratory care to patients.

3- Scope:

This policy is applicable to Respiratory therapy unit.

4- Responsibilities:

4.1 It is the responsibility of the respiratory therapists to provide comprehensive respiratory care for hospital inpatients and outpatients.

4.2 It is the responsibility of the unit manager and/or his designated personnel to offer continuing education for the staff as well as new employee.

5- Definitions:

5.1 RT care providers/therapists: Qualified respiratory care therapists/practitioners by training and/or certification in nursing/or related health care university/or college degree in respiratory care.

5.2 RT protocols: Protocols designed to ensure that: physicians respiratory care plans are carried out; therapy is appropriate, timely & driven by patient condition; cost effective strategies are appropriate; and the clinical condition in which the physician should be notified are clear and unquestionable.

6. Procedure:

6.1 Physical therapy services are provided (7) days a week on 3 shift basis for inpatients.

6.2 A respiratory therapist should perform an initial assessment within 4 hours of a referral from the general wards, and within (30) minutes for ER or ICU patients, unless the patient's condition warrants more urgent action.

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6.3 The initial assessment should include, but is not limited to the following:

6.3.1 Sputum amount, color and consistency.

6.3.2 Most recent chest x-ray report.

6.3.3 Auscultation findings.

6.3.4 Additional physical exam findings, including but not limited to: heart rate, Respiratory rate, blood pressure, oxygen saturation and temperature.

6.3.5 Available and pertinent laboratory data (e.g. ABG, pulse oximetry, and sputum cultures).

6.3.6 An assessment based on data collected, stating the current and potential Respiratory problems and any recommendations.

6.3.7 The RT carries out one or more for the treating procedures based on the physician recommendation, hospital policies and initial assessment.

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6.3.9 Treating procedures (Patient Driven Respiratory Care) used for patients on general floors and ICU patients are:

6.3.9.1 Oxygen therapy.

6.3.9.1 Prophylaxis for pulmonary complications.

6.3.9.2 Chest physical therapy.

6.3.9.3 Postural drainage.

6.3.9.4 Training for metered dose inhaler (MDI, with/without spacer).

6.3.9.5 Small volume nebulizer (SVN).

6.3.9.6 High flow therapy.

6.3.9.7 Non-invasive ventilation.

6.3.9.8 Portable spirometer.

6.3.9.9 Assisting in intubation.

6.3.9.10 Ex-tubation.

6.3.9.11 MDI/nebulized therapy for ventilated patients.

6.3.9.12 Ventilator weaning protocol.

6.3.9.13 Invasive and non-invasive ventilation.

6.3.9.14 High frequency ventilation.

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6.3.9.15 Sputum induction.
6.3.9.16 Pannel, Sputum and Trap culture.
6.3.9.17 Assisting in bronchoscopy and tracheostomy insertion.
6.3.9.18 Transfer critical ventilated patients.

6.4 Reassessment by respiratory care services should be documented and should be done when there is a significant change in condition, diagnosis or treatment plan requiring reassessment.
6.5 Reassessment of intermittent therapies should be done daily or based on the patient's condition.
6.6 The ventilated patient care plan should be updated every 24 hours.
6.7 Timeframe of reassessment may be modified to reevaluate the patient earlier if the patient's condition warrants.
6.8 Modification of respiratory therapy care treatment plan based on reassessment should be carried out according to established policies and protocols e.g. weaning protocol.
6.9 Cooperate with other health professionals to ensure holistic care to patients with diseases.
6.10 For disposable parts; all tube circuits, connections, filters and any parts directly connected to the patient should be used only for one time.
6.11 For reusable parts; all connections should be sterilized according to instruction for each part.
6.12 The respiratory therapist must receive an order once patient's service changed, referred/ transferred from a floor and or care unit to another.

7- Forms and Document:

Respiratory Care Protocols.

8- References:

1- Joint Commission International Accreditation Standards for Hospitals 7th Edition (2021), Access to Care Chapter and Continuity of Care Chapter Standard, ACC.
2- King Hussein cancer center polices, Noninvasive Positive Pressure Ventilation (NPPV), 2021.