Position Statement

AARC Position on Unattended Service ("Concurrent Therapy" "Stacking")

Introduction

The American Association for Respiratory Care (AARC) is aware of the practice of unattended service (sometimes referred to as "stacking" or "concurrent therapy") within the context of delivery of respiratory care. This white paper is issued due to the major concerns of respiratory therapists regarding the practice, centering on the issues of patient safety and quality of care, but also significantly contributing to provider burnout.

This paper outlines causes, ramifications, and alternatives to providing unattended respiratory therapy services.

The Current Health Care System Places Increased Demands on Health Care Providers

Patients with cardiopulmonary diseases need access to safe, cost-effective care. Respiratory therapists provide care that can improve patient outcomes and reduce morbidity, mortality, and costs.

Under the current healthcare system, increasing demands are placed on providers due to the aging population and a decrease in the supply of health care professionals. Respiratory therapy is impacted by these shortages as well. In 2022, according to the Bureau of Labor Statistics, there were 133,100 respiratory therapists, while the demand is for nearly 8,200 more therapists each year.[1] This shortfall in demand versus supply is expected to increase to nearly 7,000 full-time equivalents by 2036.[2] This shortfall in demand versus supply may further increase as there has been a 22.5% decrease in RT graduates compared to the peak in 2012.[3] This lack of supply has resulted in increased workloads for respiratory therapists[4] which has led, in some cases, to respiratory therapist feeling pressured to provide treatments concurrently (stacking) although it is against their best professional judgment. In the 2020 the AARC's Human Resource Survey, 28% of the respondents answered that their employers required simultaneous care to be provided to multiple patients.[4]

Although today's health care system demands increased efficiency and cost savings utilizing limited personnel, it is imperative to balance that demand with the need for appropriate, effective, and skilled patient care. In providing care, respiratory therapists are bound by ethical and professional principles and, in most cases, state practice acts.[5] To provide safe, cost-effective care, the respiratory therapy profession must address the issue of unattended service (sometimes referred to as "concurrent therapy" or "treatment stacking"). Unattended service in respiratory care refers to the simultaneous administration of multiple treatments or therapeutic interventions to manage respiratory conditions to multiple patients, simultaneously.

TJC standards do not specifically address treatments to this level of specificity. Your organization policy would address this.

The Federal Government's Response to Unattended Therapy Services (Concurrent or Stacking)
The Prospective Payment System (PPS) for Skilled Nursing Facilities (SNF), the Centers for Medicare and Medicaid Services (CMS) raised the issue of concurrent therapy. According to CMS, "individual therapy is generally the best way of providing therapy to a resident because it is most tailored to that specific resident's care needs."[6] One therapist should treat one client at a time. "This should be the primary mode of therapy and the standard of care."[6] In the health care setting patients who are receiving respiratory care services, unattended care is not the norm. The facility should prevent unattended services from occurring. Safety reporting is part of internal organizational standards in addition to external regulatory agency requirements. Any measurable safety outcomes are subject to reporting as required by regulatory agencies.

Sources of Concern Regarding Unattended Therapy Services (Concurrent, Stacking Therapy)
Medical Errors:
The appropriate administration of respiratory therapy involves assessing and monitoring the patient. Assessment and monitoring include the need for therapy, administration of medications, the type of medication delivery device and patient interface, patient education, patient tolerance, patient coordination, and outcomes documentation.[7,8] Unattended therapy services may encourage the elimination of one or more of these essential elements and could result in medical errors. A report by the Institute of Medicine notes that there are serious problems associated with medical errors, particularly medication errors.[9] These errors are often associated with inadequate staffing levels and burnout. Burnout results in a decreased quality of care[10] and is associated with an increased risk of major medical errors.[11] Again, an increased demand for efficient care, coupled with workforce shortages, has resulted in increased workloads. In some instances, such demands far exceed a facility's resources.

Ethics:
Respiratory therapists practice under the principles of non-maleficence and beneficence. "Primum non nocere," or first do no harm, is a guiding principle in medicine. Beneficence is protecting the patient from harm and preventing harmful things from happening to a patient. Leaving a patient unattended while the patient is receiving a therapeutic modality, especially when medication is being delivered, is exposing the patient to potential harm. It is not possible to assess and recognize an adverse effect to the patient, when the therapist is not in the room. The patient cannot be coached to receive the optimal benefit of the therapy if the therapist is not present.

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AARC Apex Recognition of Respiratory Therapy Departments

The AARC Apex Recognition Award is a recognition program for respiratory care departments in acute care hospitals, long-term care facilities, home medical equipment (HME) companies, educational programs, acute care international, post-acute care, and dedicated transport teams.

The AARC developed the APEX Recognition Award to recognize the significant contribution of respiratory therapists and highlight best practices in respiratory care that are aligned with evidence-based medicine. This program will also help consumers choose health care facilities that enhance patient safety and outcomes by providing access to respiratory therapists delivering high-quality, evidence-based care.

Acute care hospitals and long-term care facilities whose Respiratory Therapy Departments receive the AARC's APEX Recognition Award must have a departmental policy that prohibits the routine delivery of care to multiple patients simultaneously. The policy must include language that identifies if/when simultaneous therapy is acceptable and the mechanism by which the respiratory therapist triages the delivery of care.[12]

Alternatives to the Practice of Providing Unattended Therapy Services (Concurrent Therapy, Stacking Treatments)

The AARC appreciates the fact that even though staffing resources may temporarily be inadequate to meet the demand for respiratory services, there exist service delivery models and strategies which can close the gap between the demand for services and an institution's ability to meet that demand without jeopardizing patient safety, care quality and cost containment objectives. Brief descriptions of alternatives to providing unattended respiratory services are presented in the following paragraphs.

Protocols

The use of established protocols may help respiratory therapists deliver appropriate and efficient care under conditions of an increased workload. Protocols are based on scientific evidence and include guidelines and options at decision points.[13] The use of protocols can help assure that all therapeutic modalities/treatments have established indications and can be effective in reducing the volume of unnecessary treatments and optimize efficiency in workload.[14-21] Research has shown that there exists a high percentage of misallocated respiratory therapy treatments. The range of misallocation has been reported to be 25% to 60%, depending on the modality and the institution.[22,23] Evidence-based literature exists supporting the use of protocols to minimize unnecessary treatments [14,15,16] and For patients who require bronchodilator therapy, protocols can be effective in switching patients from small volume nebulizers to the less time-consuming metered dose inhales administered via handheld spacer devices. Alternatively, technology such as breath-activated nebulizers can be incorporated into protocols to increase efficiency without jeopardizing patient safety or quality of care.

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Assessment of the patient is an indispensable component to this process, maintaining the goals of patient safety and quality of care foremost. The patient's cognitive status, understanding of therapeutic goals, coordination, and tolerance of the therapy must be considered in the assessment. Moreover, the patient's attitude and ability to cooperate with the therapy should be recognized as indispensable to the success of the treatment itself., the proximity of the therapist must be taken into consideration, to assure adequate monitoring and ensure the quality and safety of treatment.

Self-administration of medications is an option for patients who demonstrate their ability to do so as documented by the respiratory therapists.[17] There are many instances where patients can be transitioned to a self-treatment program and thus avoid a significant demand for the therapist's time without compromising care quality and patient safety. Policies and procedures must be developed which govern patient self-administration of respiratory therapy modalities/treatments. This process should include a thorough assessment of the patient like the one described in the previous alternative. Patients can then be categorized as those who require the services of a respiratory therapist or those who, after appropriate instructions from a respiratory therapist can self-administer their therapy. Patients in the first group would be treated that traditional way, while those in the latter group should be assessed and observed daily to assure that the therapy ordered is still appropriate, the patient's clinical condition has not worsened, and the patient can still demonstrate correct technique regarding self-administration of the treatment.

The foregoing alternatives are not intended to be all-inclusive. Each theme focuses on several key areas: patient assessment, safety, quality of care, the appropriateness of the order, monitoring the patient's response to therapy, and establishing formal policies and procedures to implement the proposed alternative.[24]

Value Added Services

The respiratory care profession is currently grappling with significant challenges, necessitating a focused shift toward Value Efficiency. Defined as the delivery of evidence-based respiratory care in an efficient manner, Value Efficiency demands that we establish the worth of therapeutic modalities in terms of patient safety, quality improvement, outcomes enhancement, and cost-effectiveness.[25]

To achieve this, respiratory therapists must transition from a qualitative to a quantitative definition of value, encompassing a holistic approach that integrates efficiency across all clinical services. This shift requires prioritizing activities supported by evidence-based clinical practice guidelines while eliminating or deprioritizing those tasks unsupported by high-quality evidence.[26] This will not only enhance patient care and potentially reduce costs, crucial under prospective payment systems, but also boost job satisfaction, curtail turnover rates, and alleviate job-related stress.[27] These measures are essential for advancing the respiratory care profession amidst current challenges.

Conclusions

Patient safety is the main reason respiratory therapists refrain from providing unattended therapy services without conducting a thorough patient assessment. Indiscriminate use of unattended therapy services may lead to declines in quality and may jeopardize patient safety. Aerosolized medications administered during treatments have potential adverse reactions. Recognition of these reactions is impossible if the patient is left unattended, and thus a safety hazard exists.

Actions should be taken to remedy situations that cause concern for patient safety and appropriateness of care. Possible actions include establishing protocols, providing only value-added services, and patient self-administration. Additional actions may include reporting unsafe practices to appropriate authorities within the health care organization or regulatory health care agencies. Unattended therapy services may not only adversely affect the quality of care and patient safety but can lead to a decline in job satisfaction, contribute to burnout, and a loss of trained personnel. Such adverse results further exacerbate the shortage of health care workers. Ultimately, it is the ethical and professional responsibility of respiratory therapists to ensure their patients receive both safe and effective care of the highest quality.

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