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Immediate On-Demand Emergent Administrative Training Program for First-Time Respiratory Therapy Supervisors with Little or No Prior Supervisory Experience

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IMMEDIATE ON-DEMAND EMERGENT ADMINISTRATIVE TRAINING PROGRAM FOR FIRST-TIME RESPIRATORY THERAPY SUPERVISORS WITH LITTLE OR NO PRIOR SUPERVISORY EXPERIENCE

BY

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A doctoral project submitted to the faculty of the Medical University of South Carolina
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Chair, Project Committee	Walter Jones, Ph.D.	Date
Member, Project Committee	Kit Simpson, DrPH	Date
Member, Project Committee	James Knight, Ed.D., RRT	Date

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Abstract of Dissertation Presented to the
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IMMEDIATE EMERGENT ADMINISTRATIVE TRAINING PROGRAM FOR FIRST-TIME PROMOTED RESPIRATORY THERAPY SUPERVISORS WITH LITTLE OR NO PRIOR SUPERVISORY EXPERIENCE

By

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Committee: James Knight, EdD, RRT.

First-time frontline clinical supervisors, such as Respiratory Therapy (RT) supervisors are management officials that are often hired with little or no prior supervisory experience, and the administrative duties required of an RT supervisor are not taught as part of a clinical RT college program. This project is designed to provide an overview and an immediate on-demand emergent administrative training program for the administrative responsibilities required of a first-time RT supervisor with little or no prior supervisory experience, that are required to supervise respiratory therapists that provide critical patient care, and ensure that these respiratory therapists do not harm patients. It can take several years supervising a respiratory therapy department to learn and become proficient with the required administrative responsibilities, in conjunction with the completion of professional development courses to learn how to supervise an RT department in the most effective manner. This dissertation project will help them deal with issues when supervising an RT department for the first time, and transition into RT management as smoothly as possible.

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CHAPTER I

INTRODUCTION

1.1 BACKGROUND AND NEED

Future Needs of Respiratory Therapists: Based on a prediction from the Bureau of Labor Statistics by 2029 the nation will need an additional 26,300 Respiratory Therapists (AARC5, 2020), and the job to attract new people into the respiratory care profession will fall on the educators to fill seats in their respiratory therapy programs (AARC5, 2020).

Breakdown of Respiratory Therapy Academic Programs: As of December 31, 2019, the Respiratory Therapy (RT) profession had 420 academic programs, and of these RT programs, 345 (82% of total) were at the associate degree level, 70 (17% of total) were a bachelor's degree programs, and five (1% of total) were master's degree programs (CoARC, 2019)(see Appendix A). There is Doctorate in RT, however I found five Universities that offer a Ph.D in Health Sciences or Health Professions with an emphasis in cardio-pulmonary care.

Breakdown of Respiratory Therapist's Credentials: According to the National Board of Respiratory Care for 2019 there were 256,605 Certified Respiratory Technicians and 169,240 Registered Respiratory Therapists (NBRC, 2020)(see Appendix B).

Breakdown of Respiratory Therapists Duties: Based on the Job Qualification Statement from the Department of Veterans Affairs VA Handbook 5050, Part II, Appendix G11, April 15, 2002 (VHA, 2002) , the breakdown of position titles for RT staff are (see Appendix C) as follows for: Certified Respiratory Therapists GS-7 (II-G10-1), Registered Respiratory Therapists GS-8 (II-G11-1), Supervisors of RT GS-9 (II-G11-1), Assistant Chief of RT GS-10 (II-G11-3), and the Chief of RT GS-11 (II-G11-4).

The Chief of RT is one of the most difficult and stressful management position(s) in a healthcare organization (AARC4, 2020). The position requires functioning with awareness 24 hours a day, seven days a week at all times without fail, and this demand has become more important as a result of the COVID19 crisis, which has demonstrated the increased need for respiratory therapists to be supervised. First-time inexperienced RT department supervisors are management officials, who are hired with a tremendous amount of responsibilities that are not taught as part of a clinical RT college program, that are required to supervise respiratory therapists in a healthcare organization to ensure that Respiratory Therapy care is provided in a safe and effective manner. For these reasons, healthcare organizations should provide an immediate emergent administrative training program primarily for first-time RT supervisors when they initially accept a supervisor's appointment, delivered through a set of digital education modules, or in a PowerPoint presentation to address their lack of administrative training that is not taught in clinical Respiratory Therapy educational programs.

1.2 PROBLEM STATEMENT

The administrative responsibilities of first-time RT supervisors are not taught as part of a clinical RT college program, and I am not aware of a detailed on-demand emergent administrative training program primarily for a first-time RT supervisor with little or no prior supervisory experience offered to first-time RT supervisors. Healthcare organizations do offer professional development courses that are scheduled sporadically over time through their educational department(s), but these may not be available on-demand when a first-time RT supervisor is hired. These courses do not offer an immediate or comprehensive training program for an RT supervisor's administrative responsibilities to the extent outlined in this dissertation project. It is ironic that RT staff who are required to provide direct critical patient care are

frequently supervised by first-time RT supervisors who have little or no administrative management training, and there is no immediate effort to fill their administrative training gap.

When there is an RT supervisor vacancy, and the vacancy announcement is posted for that position, it usually will state a specific number of years of supervisory experience is "preferred." The "preferred" clause gives a healthcare organization the legal option to hire an outstanding Respiratory Therapist that has displayed some good management potential without having prior supervisory experience. Just because a respiratory therapist has done a good job as a respiratory therapist does not mean he or she will make a good RT supervisor, and this does come with some potential liability to the healthcare organization considering the type of issues that have to be dealt with. However, this does give an outstanding inhouse respiratory therapist an opportunity for upward mobility and it is also encouraged in the bargaining unit agreement with the Union, and it is a Human Resource (HR) recruitment option that promotes morale.

For example, RT supervisors are hired frequently without prior experience in the Department of Veterans Affairs (VA) when there is an unexpected vacancy to promote upward mobility or temporarily until they decide if they want to select from the outside. It is also done particularly in high cost of living areas of the country, such as the San Francisco Bay area. Hospitals in the San Francisco Bay area pay their staff respiratory therapists approximately as much, or more than what the VA pays the Chief of RT in the San Francisco VA Medical Center, and that makes it difficult for the VA to hire RT supervisors and staff. Taking all that into consideration along with the fact the RT Chief is a very stressful position with a substantial high turnover rate. There are times when management will have no other choice than to hire a respiratory therapist without prior supervisory experience into an RT supervisory position, particularly in the Federal Government, and there should be some type of immediate on-demand

emergent administrative training available.

The evolution of the Respiratory Therapy profession has been slower than other clinical professions. In 1943 a primitive inhalation therapy program was established by training RT technicians on-the-job to manage post-surgical patients by Edwin R. Levine, MD at the Michael Reese Hospital in Chicago (AARC13, 2021).

Later in 1960 The American Registry of Inhalation Therapists (ARIT) was formed and became The National Board for Respiratory Therapy in 1974, and in 1982 California was the first state to require a state license to practice respiratory therapy and a license to practice Respiratory Therapy is still not required in all 50 states like other clinical professions.

In 1986 the American Association for Respiratory Therapy (AART) became the American Association for Respiratory Care (AARC) (AARC13, 2021), and then in 1990 The AARC started developing the Clinical Practice Guidelines (CPGs) for the respiratory therapy profession (AARC13, 2021), but no Administrative Practice Guidelines (APG) or an Administrative Training Program was developed for RT supervisors as part of the RT Profession.

1.3 POPULATION

This project is primarily intended for first-time inexperienced respiratory therapy supervisors, and it can be used for newly hired RT supervisors with one to four years of experience that has never had the benefit of an administrative training program, and this program can be used as part of the orientation process as a refresher when hiring an experience RT supervisor. This dissertation project can also be used to teach RT students so they will have some idea of the administrative duties that are expected of them as future RT supervisors.

CHAPTER II

LITERATURE REVIEW

2.1 LITERATURE REVIEW

Based on the literature I have reviewed, I have created an immediate emergent training program for the administrative duties required of an inexperienced first-time RT supervisor, that are required to supervise respiratory therapists to ensure they do not harm patients. There is a need for this type of on-demand administrative training program because RT supervisors have the administrative responsibilities to enforce the policies and procedures, rules, regulations, and laws, and administrative responsibilities of a first-time RT supervisor are not taught as part of a clinical RT college program. In the absence of administrative training these obligations must be learned on-the-job after an inexperienced RT supervisor has accepted a position. This doctoral project offers a unique training program developed to facilitate the transition into RT management as smoothly as possible for first-time RT supervisors. It provides them an immediate on-demand emergent administrative training program with a PowerPoint presentation, or in a set of Digital Educational Modules for the administrative duties that are needed to run a Respiratory Therapy department in the most effective manner.

In hindsight, when I was an inexperienced first-time Respiratory Therapy supervisor, I now see where I would have benefited from the teachings of Dr John Kotter (Kotter, 2011). That is why I used his literature as part of this immediate emergent administrative training program because a respiratory therapist supervisor should understand the principles of “change management” that is intended to keep the change effort under control, as compared to “change leadership” that pushes for a vision to bring on a large-scale transformational change in culture

(Kotter, 2011). An RT supervisor should be trained in the "Kotter's 8 Step Change Model" to make culture changes in an RT department in the best manner possible (Mulder, 2014).

A hospital is a collection of administrative and clinical services, and every department and section supervisor, including an RT supervisor, should have a compliance program based on the HHS Office of the Inspector General's (OIG) seven essential elements of an effective compliance program (HHS OIG, 1998). For this reason, I have use the OIG literature on healthcare compliance as part of this dissertation project to develop an immediate on-demand emergent administrative training program for inexperienced first-time RT supervisors. I have also reviewed literature from the Pro Quest Healthcare Administrative Database titled, "The transition from worker to supervisor: Five common mistakes" (Bielous, 1994). This work speaks to the five common mistakes made by first-time supervisors.

I also contacted the American Association of Respiratory Care to research this issue on October, 13, 2020. I found out that the AARC has addressed aspects of my dissertation topic as of 2014, to provide a real-world education for respiratory therapists who wish to expand their knowledge beyond the clinical realm" through the AARC Leadership Institute (AARC8, 2020). From the AARC leadership Institute, I came across the "Six Thinking Hats" by Edward de Bono offered by Cheryl A Hoerr, MBA, RRT, CPFT, FAARC. The "Six Thinking Hats" is a method that symbolically encourages an individual to put a color to a thought process with a team to break down complex situations for analysis (Lucidchart, 2020).

CHAPTER III

METHODOLOGY

3.1 QUALITY IMPROVEMENT PROGRAM EVALUATION SELF-CERTIFICATION

This dissertation project proposal has been submitted through the Medical University of South Carolina (MUSC) Quality Improvement (QI) Program Evaluation Self-certification (see Appendix D), and a determination has been made that this project is a Quality Improvement Program Evaluation Project. Consequently, this project does not fit the federal definition of research, and a certification letter has been provided that an Institutional Review Board review is not required (see Appendix E).

3.2 GUIDED INTERVIEWS

I have used a qualitative method based on one-on-one guided interviews for this dissertation project (QuestionPro, 2020). The reason I have selected guided interviews with RT professionals is because I am under the impression with 26 years in the RT profession that this is the first-time an on-demand emergent administrative training program has been developed to the extent I have created, and I have consulted and interviewed several very experienced RT professionals to validate the need and premise of this dissertation project. First, I made contact with the RT supervisors for one-on-one guided interviews by sending them via email with an outline of the immediate emergent administrative training program curriculum, along with asking for permission to include them as one of my professional RT contacts to conduct a guided interview with as an example (see Appendix F) to Brian Daniels.

The guided interviews were conducted with five individuals with 20 to 40 years of RT supervisor's experience and RT education with knowledge of important issues in the RT

profession. After they received my email I contacted them via the telephone and conducted a guided interview with them, and after the completion of the guided interviews I subsequently received a requested email response from the professional RT contacts I conducted the guide interviews with as follows:

I. **Brian Daniel, RRT:** 34 years in the RT profession with 17 years' experience as the Director of Clinical Education, at the Skyline College Respiratory Therapy program, San Bruno, CA. Brian Daniels indicated that he agreed with the premise of my dissertation and that there is a lack of succession planning for respiratory therapy leadership and education (see Appendix G).

II. **Shawna Strickland, PhD, RRT:** Associate Executive Director of Education for the American Association for Respiratory Care (AARC), who informed me that, the AARC has data on my project topic in the AARC Leadership Institute, to provide real-world education for Respiratory Therapists who wish to expand their knowledge beyond the clinical education taught in RT programs (AARC, 2020). Ms. Shawna Strickland felt there is value to my dissertation project and informed me as quoted, "after your dissertation is completed, we can definitely talk about how this content may benefit AARC members and the AARC educational portfolio" (see Appendix H).

III. **Eugene Benjamin, RRT:** Chief of Respiratory Therapy for Montefiore New Rochelle Hospital, with 40 years' in the RT profession with 25 years' of RT supervisor's experience and 20 years' combine teaching experience between the Long Island University and New York University RT programs. Eugene Benjamin has indicated that he thinks the administrative program I have created is a good idea, and he has never seen an administrative training like I have created for first-time RT supervisors, and this on-

demand emergent administrative training program has been long overdue in the RT profession (see Appendix I).

IV. **Rosemary Williams, MHA, RRT:** Director of Respiratory Therapy at Kindred Hospital, San Leandro, CA, with 35 years' experience in the RT profession with 20 years' experience as an RT manager and 10 years' experience teaching in the Kaplan College RT program. Rosemary Williams stated that this on-demand emergent administrative training for first-time RT supervisors would be a good idea for new recently hired RT supervisors with one to four years of RT supervisor's experience that has not had the benefit of an administrative training program like I have designed (see Appendix J).

V. **James Knight, PhD, RRT:** Chief of Respiratory Therapy at the Woodhull Hospital seven years, with 34 years' experience in the RT profession, and 16 years' experience as the past Director of Clinical Education for the Long Island University bachelorette RT program. Dr James Knight has indicated that my dissertation project is a good idea and that it could play a valuable role in the orientation process when new RT supervisors are hired (see Appendix K).

A great deal is known that has never been developed into an on-demand emergent administrative training program primarily for first-time RT supervisors with little or no prior supervisory experience. It is impossible to teach an inexperienced first-time RT supervisor everything they may need to know with this administrative training program when they initially accept an appointment.

However, there are certain areas that should be covered immediately when an inexperienced first-time RT supervisor initially accepts a supervisor's appointment to provide

them with some management advice and education, that is not taught as part of a clinical RT college program. Consequently, I have consulted with and conducted guided interviews with experienced RT professionals and developed this immediate on-demand emergent administrative training program primarily for first-time RT supervisors consisting of 21 sections in chapter four to learn the administrative duties that are required of them as soon as possible to facilitate a smooth transition into RT management.

CHAPTER IV

RESULTS

I have created an “Immediate On-demand Emergent Administrative Training Program for first-time RT supervisors with Little or No Prior Supervisory Experience,” that consist of 19 sections in chapter IV from my:

- Doctor of Health Administration (DHA) program.
- Literature research.
- Study Design One-n-One Guided Interviews with peers in the RT profession.
- Master of Jurisprudence in the Health Law Compliance program.
- Department of Veterans Affairs Administrative Training program.
- My personal experiences as a first-time promoted RT supervisor with very little prior RT supervisory experience.
- Bachelor of Science in Respiratory Therapy program.

4.1 MISTAKES NEW MANAGERS MAKE

Usually first-time RT supervisors are initially very nervous and very cautious to protect their first RT supervisor position, and the first thing an inexperienced first-time RT supervisor should be aware of is that nobody is going to tell you how to do your job, and nobody is going to tell you what mistakes not to make. There is a great deal of literature written on the mistakes that inexperienced first-time supervisors make, and a first-time supervisor should research this literature when they initially accept an appointment to help them transition into RT management as smoothly as possible. As an example, I am providing in this administrative training program an article from the Pro Quest Healthcare Administrative Database titled, "The transition from

worker to supervisor: Five common mistakes, by Gary Bielous. The five common mistakes of first-time supervisors are as follows (Bielous, 1994):

I. **Too eager to please:** First-time supervisors want to prove themselves to everybody in the workplace, such as superiors, peers, subordinates and others through the organization, to demonstrate the right person was selected for the job. From personal experience a new first-time RT supervisor should address issues and problems slowly to give themselves a chance to consider all the consequences involved in an RT issue (Bielous, 1994).

A new first-time RT supervisor needs to understand all RT supervisors that have supervised people for a long time will take many disciplinary actions and make many administrative decisions and when they look back on their career there will be a few times they wished they done things differently, as go the old saying goes "hindsight is 2020 vision." When a first-time RT supervisor takes over their first RT department they are naturally nervous and the discretions they would take as an experience long time RT supervisor will not be taken as a first-time promoted RT supervisor. A great deal of the time a first-time RT supervisors are eager to take a disciplinary action and often do not consider all the ramifications with everybody that might be involved and affected when it actually might not be necessary. A first-time RT supervisor should try not to appear as if he or she only makes their worth when they taking a disciplinary action.

First-time RT supervisors are frequently nervous and scare and are not going to take any chance of losing a job that is an opportunity they have been waiting a long time for, and they will be reluctant to use the certain discretions as a first-time supervisor that they will use when they become more experienced because they may think they are making the right decision. This will cause a new RT supervisors with important issues to

periodically make decisions without considering all the ramifications and other available options to handle a problem until they have gained more experience. Until have gained more experience they should consult with someone more knowledgeable and experienced (e.g. another RT supervisor in the area, or a Nurse manager) to listen and learn about how to handle the problem in the best way possible.

This is very important because a first-time supervisor is going to make decision that involve upper and lower management, supervisors and staff from other departments, human resources and the entire hospital administration. First-time RT supervisors should use the “three Ls**":** Listen, Learn and Lead (Bielous, 1994)**:**

A. **Listen**, to what people have to say about how they perceive things in the workplace. It is a good practice to listen and ask "what" and "how" questions to solicit information before making a decision. This will help a supervisor determine what is a fact versus what is not true to make a decision on an issue.
B. **Learning**, about the inner workings of your department and organization is very important and will take some time to find out who is competent, who you can trust, who is influential, and who is not. Eventually, you will need to make short and long term goals and obtain them through people that you supervise and through other people you need to achieve your objectives. That is why it is advisable to wait some time before making a major decision, and if the job will not allow you to wait while you are a new first-time RT supervisor, then discuss the major issue with your superiors before you make a major decision for your own professional protection.
C. **Lead**, by example and be proactive and reactive when it applies to the situation. Being a positive role model is very important because employees will embrace and

practice your positive behavior. The best way to lead is in a positive manner, or your employees will definitely do the opposite.

II. **Promises not kept:** First-time RT supervisors should not make promises they cannot keep, because you can lose your credibility with your staff. If you promise something (e.g. more money, or extra time off) and you fail to keep your promise, you should carefully explain what happened to the employees that you made the promise with. Additionally, it is important not to blame other people for your inability to keep promises you to have made. It is best to admit your mistake, learn from it and not do it again (Bielous, 1994).

III. **Pointing fingers:** When a first-time supervisor does not keep a promise, or makes an unpopular decision, they should take accountability for their actions. They should not shift the blame because they will lose the respect of their staff. You should secure your upper-management support before making a decision, then you can take full responsibility without fear if something goes wrong (Bielous, 1994).

IV. **Doing employees' work:** First-time promoted RT supervisors initially find it difficult not to do patient care. From personal experience new supervisors will miss the adrenaline rush when they hear a cardiac code over the loudspeaker. They just want to be helpful, and still think they are the best Respiratory Therapist in the department. New RT supervisors need to understand they are not the functioning RT staff anymore, and they need to achieve department goals through people to be successful. RT supervisors have plenty of administrative duties to keep them busy, especially for a new RT supervisor who has just taken over an RT department. However, it is important for an RT supervisor to practice RT on some type of consistent basis to maintain their clinical

skills, and that can be done when covering for staff shortages and emergency coverage (Bielous, 1994).

V. **Favoritism:** New RT supervisors should be aware of how easy it is to be perceived as showing favoritism, because many first-time supervisors make that mistake. It is very easy to get caught up into a favoritism problem, especially for those promoted from within the RT department over the RT friends they used to work with. New supervisors will set boundaries with people that they used to work with because, some people will try to take advantage of their prior friendship. New RT supervisors should be aware that showing favoritism can destroy their credibility with other RT staff, and depending on how severe the favoritism is, it can cost them their job. Keep your relationship with the staff that you supervise on a professional level only.

4.2 CREATIVE THINKING

Based on the, Six Thinking Hats, by Edward de Bono who wrote, "Creative thinking is not a talent; it is a skill that can be learned. It empowers people by adding strength to their natural abilities which improves teamwork, productivity, and where appropriate, profits" (quoted in Lucidchart, 2020). Edward de Bono was a physician, author and consultant who taught thinking as a subject in school to help people be successful in life (Lucidchart, 2020). The American Association of Respiratory Care Leadership Institute has presented the Six Thinking Hats in the Leadership and Team Building course offered by Cheryl A Hoerr, MBA, RRT, CPFT, FAARC. The Six Thinking Hats technique can prepare a first-time RT supervisor to make better decisions quickly, and that is a must-have talent in order to run an RT department.

Running an RT department is a team effort and the Six Thinking Hats technique helps a team consider decisions from several different viewpoints. It helps Respiratory Therapy team

members to think differently about an issue to realize the overall complexity of a decision, and recognize issues and opportunities they might have otherwise overlooked in the decision making process. The Six Thinking Hat is a method that symbolically encourages an individual to put a color to a thought process with a team to break down complex situations for analysis. This maintains structure and allows for flexibility in the thought process with the six different ways of thinking that are associated with the Six Thinking Hats colors as follows:

I. **The White Hat is for Neutrality:** The white hat gathers as much data as possible to analyze the problem, and should remain unbiased and neutral to avoid prematurely jumping to conclusions. When gathering data to analyze a problem use these type of questions:
   - **A.** "What do we know about this issue?
   - **B.** What don't we know about this issue?
   - **C.** What can we learn from this situation?
   - **D.** What information do we need to solve this problem?
   - **E.** Are there potential existing solutions that we can use to solve this problem?" (Lucidchart, 2020).

II. **The Yellow Hat is for Positive Judgment:** The yellow hat helps the person to think positively with optimistic perspectives to help see all the benefits and value of all decisions with the problem. Yellow hat thinking helps motivate focus on solving a problem when in a difficult situation. Yellow hat questions to solve a problem can include:
   - **A.** What is the best way to approach the problem?
   - **B.** What can we do to make this work?

C. What are the long-term benefits of this action? (Lucidchart, 2020).

III. **The Black Hat is for Negative Judgment:** Black hat is used to look for weaknesses, barriers, risks, mismatches, and the dangers of proposed ideas. This is important because it allows the preparation of contingency plans to counter them. Questions asked from the black hat perspective can include:

A. How will this idea likely fail?

B. What is this idea's fatal flaw?

C. What are the potential risks and consequences?

D. Do we have the resources, skills, and ability to make this work? (Lucidchart, 2020)

IV. **The Red Hat is for Feeling:** Wearing the red hat, problems are analyzed using intuition, feelings, gut reaction, and hunches. This hat is open-minded and non-judgmental and take into consideration how other people will react emotionally to a decision, and understand people may not fully understand the reasoning for a decision. The objectives of a red hat thinker are:

A. Make intuitive insights known.

B. Seek out a team's hunches and feelings.

C. Reveal an idea's hidden strengths.

D. Use instinct to identify potential weaknesses.

E. Find internal conflicts. (Lucidchart, 2020)

V. **The Green Hat is for Creative Thinking:** The Green hat is where you can use creative thinking to think out of the box, and consider other possibilities free from judgement and criticism. This is where no idea is too ridiculous to be considered or immediately disregarded. When wearing the green hat questions to ask include:

A. Do alternative possibilities exist?

B. Can we do this another way?

C. How can we look at this problem from other perspectives?

D. How do we think outside the box? (Lucidchart, 2020)

VI. The Blue Hat is for The Big Picture: Wearing the blue hat requires management's control of the problem solving for process. It is the supervisor's job to ensure that all hats are working as a team, and make sure the team stays focused and work efficiently to solve a problem. The blue hat seeks to:

A. Efficiently and effectively improve the thinking process.

B. Ask the right questions that help direct and focus thinking.

C. Maintain and manage agendas, rules, goals, and tasks.

D. Organize ideas and proposals, and draw up action plans (Lucidchart, 2020).

Nothing is more important than using creative thinking when work together as a team. People are not always going to tell you what you need to know, or how to do something. In order to be successful, a supervisor must learn how to analyze a situation and make the best possible decision to address a problem.

VI. Deductive and Inductive reasoning: A first-time inexperienced RT supervisors should understand the difference between deductive and inductive reasoning because those critical thinking skills are going to be needed on a daily basis to run an RT department. They are also needed when an RT supervisor as a clinical department supervisor is summoned to be part of a Root Cause Analysis (RCA) committee to investigate a patient care issue, or any other type of investigation that might be necessary.

The difference between deductive and inductive reasoning is not generally taught in a clinical academic RT program. Inductive reasoning generalizes a conclusion from specific

observation(s) (Bradford, 2017), and there are times when that might work out well in common routine issues. However, inductive reasoning can be a dangerous practice in Respiratory Therapy depending on the circumstances because there are several clinical conditions that have the same observed symptoms that are treated differently.

For instance, hypoxemia is defined an abnormally low level of oxygen in the blood, and there are several clinical condition(s) that can cause hypoxemia. For example "Refractory Hypoxemia" which is an uncommon but is an emergency situation with an abnormal low level of oxygen in the blood, and may be treated differently from other clinical conditions that can cause hypoxemia (Mehta, 2016). The application of oxygen for hypoxemia does come with some risk(s) and benefits to treat hypoxemia depending on the patient's clinical condition (Budinger, & Mutlu, 2013).

Deductive reasoning is based on the observation(s) of fact(s) that are considered true to come to a conclusion (Bradford, 2017). Deductive reasoning is not 100 percent fail-safe to come to an immediate conclusion based on the observed fact(s) that the clinical team might perceived as true, and still be wrong, and in that case the clinical team will continue to collaborate with each other using inductive and deductive reasoning with the process of elimination to figure out what is the answer to a problem. In that case I have seen a situation where everybody on the clinical team was wrong after deep collaboration and one sole doctor comes along and makes a suggestion based on a counterintuitive fact that everybody else on the clinical team had inadvertently overlooked. The point I am trying to make is to keep in mind there may always be an additional consideration to be made before you make a final decision on a matter, and always make an extra effort to find out if there is something you may have overlooked with someone you trust before settling on a final conclusion.

As a first-time RT supervisor eventually you will have to teach other Respiratory Therapists with less experience than what you have, on how to approach a problem. For example, when interviewing a new RT graduate for a position they are hyped up anticipating to answer clinical questions that they have memorized from their RT program to prove to the interviewer they are ready to work and treat sick patients. However, from my past experience as an RT interviewer the last thing a new RT graduate expects to be asked is, "Explain to me how the respiratory system works for a normal healthy person?" Usually the interviewee will give you that deer in the headlights look before they make an attempt to answer the question.

The reason I would ask that question is because if a respiratory therapist can't articulate how the respiratory system works for a normal healthy person, then how can one expect them to be able to know how to treat the respiratory system when a patient is sick. I would never expect a new RT graduate to get the question 100 percent correct, but if they made a respectable effort I would still hire them. I have asked one RT student with a 4.0 GPA the same question and have got a better response from student(s) with a lower grade point average.

The different ways the respiratory system can function from one clinical condition to another is the first thing a respiratory therapist should consider before approaching a respiratory therapy problem because baseline vital signs and arterial blood gas measurements (ABG) and other clinical indications are different from one sick patients to another depending on the patient's clinical condition. Therefore, understanding the use and limitations of inductive and deductive reasoning with the process of elimination are very important creative thinking strategies used to come to a conclusion for a clinical or administrative problem.

4.3 ORGANIZATIONAL CULTURE

Organizational culture is not taught as part of a clinical RT college program, and first-time RT supervisors probably will have to make culture changes within an RT department. An immediate emergent administrative training program should provide a first-time RT supervisors with an understanding of the principle of "change management," which is intended to keep the change effort under control, compared to "change leadership," which pushes for a vision to bring on a large-scale transformational change in culture (Kotter, 2011).

This section will provide expectations and encouragements directly from the Senior management C-suite down to first-time RT supervisors. This way first-time RT supervisors will understand and feel comfortable in their environment. This will help them not to overreact or underreact to situations when they occur and permit them to get off to a good start. To make cultures changes in the RT department in the best manner possible this section provide(s) the guidelines of Dr. John Kotter 8 Step Change Model (Mulder , 2014), and from Kotter, J. P. (1996). *Leading change, with a new preface by the author* (p. 34). Harvard Business Review Press. Kindle Edition as summarized below:

- **Step 1. Create a sense of urgency:** According to Kotter this is the most important step, and it is essential to make employees aware of potential threats and the need for change with open, truthful and persuasive discussion, that should include discussing possible solutions with the employees.
- **Step 2**. **Create a guiding coalition:** As a first-time RT supervisor more than likely there may be a need to make changes in the RT department, and the first thing this supervisor must do is discuss these issues with all the respiratory therapists in the RT department,

convincing them of the need to make necessary changes, as well as soliciting and considering their input on how to make those changes.

- **Step 3. Create a vision for change:** Once a respiratory therapist is promoted to an RT supervisory position they must develop a short term, and long term vision for changes in the RT department. The objective of the changes has to be clearly understood by the RT staff, and a strong effort has to be made to solicit ideas and concerns from the RT staff, to get their buy-in.
- **Step 4. Communicate the vision:** It is essential to discuss a vision for change with the RT staff and consider their ideas and concerns to get buy-in for their support.
- **Step 5. Remove obstacles:** Meet with all the RT staff in a group and one-on-one to determine who might be resistant to necessary changes, and encourage their acceptance to work as part of a team to make needed changes and making a final decision with their input.
- **Step 6. Create short-term wins:** Achieving short term goals is very important to convince and motivate the team to achieve long-term objectives. Rewarding the team for short-term goals, this will demonstrate that the changes are having a positive effect for the company, department or section.
- **Step 7. Consolidate improvements:** According to Dr Kotter total change based on a long-term objective is a slow, incremental process with several short-term gains.
- **Step 8. Anchor the changes:** Changes made within a respiratory therapy department must be consistent with the culture of the entire organization from the senior management in the C-suite to the lowest ranking paid employees in the organization.

4.4 HOSPITAL COMPLIANCE

A first-time Respiratory Therapy supervisors with little or no prior supervisory experience should meet with hospital's compliance officer as soon as possible because they are a frontline management official that are an extension of the Hospital's compliance officer authority. The RT supervisor is responsible to write the policies and procedures for the respiratory therapy department that are a part of the overall hospital compliance program. From the hospital's compliance officer a first-time RT supervisor should learn a brief history of hospital compliance so they will the evolution and importance of healthcare compliance to convey to the RT staff they required to supervise.

Based on the article, "The History of the Organizational Sentencing Guidelines and the Emergence of Effective Compliance and Ethics Programs" by Ketanji Brown Jackson and Kathleen Cooper Grilli the guidelines to establish effective healthcare compliance programs evolved from chapter eight of the 1991 U.S. Sentencing Commission Guidelines Manual (Jackson, 2012), then from the HHS Office of the Inspector General (HHS, 2021) in 1998 the OIG established the seven essential element of an effective compliance program in the "Federal Register / Vol. 63, No. 35 / Monday, February 23, 1998 / Notices Pages 8989 through 8997 (HHS OIG, 1998). Later in 2010 with the enactment of the Patient Protection and Affordable Care Act Patient Protection, Public Law 111–148, Title VI (Sub E) § 6401(8) (OLC, 2010) (See Appendix L) healthcare compliance programs have become mandatory by all healthcare organizations that accept Medicare and Medicaid funding. The seven essential elements of an effect compliance program from OIG are as summarized below:

I. **The designation of a compliance officer and compliance committee:** The compliance program should be led by a well-qualified compliance officer, who is supported by a compliance committee (HHS OIG, 1998, p.8993).

II. **Development of compliance policies, and procedures, including the Code of Conduct:** Compliance policies and procedures should be written on a level that is easy to read and understand to help employees remain in compliance while in the performance of their duties. The Code of Conduct is a separate stand-alone document which all employees must indicate in writing that they have received, read, and understood on an annual basis. Standards of conduct must be distributed to all directors, officers, managers, employees, contractors, and medical and clinical staff members (HHS OIG, 1998, p.8989).

III. **Developing open lines of communications:** Open communications are a product of organizational culture to encourage the reporting of potential fraud and abuse (HHS OIG, 1998, p.8985).

IV. **Appropriate training and education:** Training and education staff adequately reduce or eliminate risk liability for the violation of healthcare fraud and abuse laws (HHS OIG, 1998, p.8994).

V. **Internal monitoring and auditing:** Effective auditing and monitoring plans help hospitals prevent the submission of incorrect claims to health care program payers. The metrics used in monitoring and auditing are surveys, audits conducted by walk-throughs, sampling claims, reviewing existing reports, verify expenditures, and consider contractual obligations (HHS OIG, 1998, p.8996).

VI. **Response to detecting deficiencies:** The goal is for hospitals to respond consistently to all detected deficiencies, and develop effective corrective action plans to prevent further losses to federal health care programs (HHS OIG, 1998, p.8997).

VII. **Enforcement of disciplinary standards:** Hospitals must create an organizational culture that emphasizes ethical behavior and compliance (HHS OIG, 1998, p.8995).

VIII. **Making a Risk Assessment:** In the compliance industry making a risk assessment is considered an eighth element to a compliance program, that allows officials who are responsible to oversee and assign oversight for the roles of the risk management process for corrective action. Every year the Chief Compliance Officers will review the latest OIG Work Plan to provide independent and objective reporting to the Executive management for the purpose of bringing about positive change in the integrity, efficiency, and effectiveness of the hospital operations that includes the RT department. The OIG Work Plan offers insights to conducts audits, evaluations, investigations, and inspections of the hospital programs and operations to provide oversight of activities performed or financed by the healthcare organization.

In order to have an effective compliance program reviewing the OIG Work Plan for " risk guidance" is essential to compile and present findings. To make recommendations to adjust or change policies and practices to guarantee conformity with law and compliance guidance; promotes economy, efficiency, and effectiveness; and to detects criminal activity, waste, abuse, or mismanagement in the RT department and other departments throughout the healthcare organization.

A. **Risk Scoring Model:** After gaining sufficient context into pertinent risk they will be cataloged and prioritized. The best practices favor scoring focus on:

1. **Severity:** Impact a risk has or will have on an organization (see Table 3, p.37).
2. **Likelihood:** Probability that risk will occur (see Table 4, p.37).

B. **Risk Scoring: Heat Map:** Once the Severity and the Likelihood has been scored, the value of Severity and the Likelihood is then multiplied by each other and applied to a risk scoring heat map (see Table 5, p.37). Then the risks are cataloged and prioritized to be managed for corrective action and future prevention.

RISK SCORING SCALE: SEVERITY		
Score	**Impact**	**Description**
1	Negligible Impact	Little or no impact on achieving outcome objectives
2	Low Impact	Minor impact on achieving desired results. May not meet goals, but will be well above average expectation.
3	Moderate Impact	One or more major objectives will not be met. Possible exceed average expectation.
4	Significant Impact	Significant impact on achieving results. Multiple objectives will not be met. Possible operational and financial adverse impact.
5	Catastrophic Impact	Critical outcomes will not be met. Noncompliance with law. Reputational/Legal harm may result.

RISK SCORING SCALE: LIKELIHOOD		
Score	**Probability**	**Description**
1	Exceptionally Unlikely	<5%
2	Very Unlikely	5-35%
3	Equally as likely or unlikely	35-65%
4	Very Likely	65-95%
5	Certainty	> 95%

LIKELIHOOD						
	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
	0	1	2	3	4	5
	SEVERITY					

First-time RT supervisors should meet with the Hospital Compliance Officer as soon as possible after they accept the position to acquire an understanding of the terminology associated with compliance: fraud, waste and abuse, effective communications, the whistle-blower protection statute known as "Qui Tam," and to gain knowledge and understanding of the penalties of the primary healthcare compliance laws. These laws include but not limited to, The False Claims Act, The Anti-Kickback Statue, Civil Monetary Penalty Law, The Exclusion Provision, The Stark Law (aka) the Physician Referral Law, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Occupational and Safety Health Act (OSHA). This information should be in the front part of the respiratory therapy department's policies and procedures manual for all the RT staff to have access to and read as stated:

I. **Fraud in healthcare is defined as (OIG, 2018) as follows**:

A. Submitting claims for services not provided or used.

B. Falsifying claims or medical records.

C. Misrepresenting dates, frequency, duration or description of services rendered.

D. Billing for services at a higher level than provided or necessary.

E. Falsifying eligibility.

F. Failing to disclose coverage under other health insurance.

II. Waste in healthcare is defined as (OIG, 2018) as follows:

A. Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs.

B. Note: It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

III. Abuse in healthcare is defined as (OIG, 2018):

A. A pattern of waiving cost-shares or deductibles.

B. Failure to maintain adequate medical or financial records.

C. A pattern of claims for services not medically necessary.

D. Refusal to furnish or allow access to medical records.

E. Improper billing practice.

IV. Effective Communication with Physicians:

A. Respiratory Therapists have a duty to question RT orders that are contrary to their clinical and professional judgment.

B. Questions, Concerns and Disagreements about a respiratory order should first be addressed to the ordering physician with etiquette in a tactful manner. If necessary; further concerns should be brought to an RT supervisor on duty, and then referred the matter to the RT Medical Director and up the medical chain of command, and if the matter is not resolved the Compliance Officer should be contacted for help.

A. Also, in Qui Tam actions, the government has the right to intervene and join the action. If the government declines, the private plaintiff may proceed on his or her

own. Some states have passed similar laws concerning fraud in state government contracts (LII, 2020).

VI. The False Claims Act 31 U.S.C. §§ 3729-3733:

A. Also known as the ("'Lincoln Law") has become the primary tool in the government's arsenal to Combat against fraud against the government. It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. The two liability provisions that are most often used in FCA litigation are:

1. The false claims provision: This creates liability for knowingly presenting, or causing to be presented, a false or fraudulent claim for payment (31 U.S.C. § 3729(a)(l)(A)).

2. The false statement provision: This creates liability for knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim (31 U.S.C. § 3729(a)(l)(B)).

3. Penalties under the False Claim Act are: Federal penalties can total three times the amount of the claim, plus fines of $5,500 to $11,000 per claim (OIG, 2020).

a) Qui Tam Provision under the False Claim Act 31 U.S.C. § 3729 to 3733: This can be result in people who Qui Tam complaints receiving 30 percent of the monies recovered by the government as a reward and he or she is protected against retaliation.

b) Qui Tam, under the False Claims Act, allows persons and entities with evidence of fraud against federal programs or contracts to sue the wrongdoer on behalf of the United States Government.

VII. The Anti-Kickback Statue: 42 U.S.C. § 1320a-7b:

A. ls a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of business from a federal health care program business. This is important for RT Managers, because they come in contact with many different vendors for Durable Medical Equipment, and other RT services where the temptation of a kickback is possible.

1. Criminal penalties for the Anti-Kickback statue are:

a) Fines up to $25,000 per violation.

b) Up to a 5 year prison term per violation Civil / Administrative.

c) False Claims Act liability.

d) Civil monetary penalties and program exclusion.

e) Potential $50,000 Civil Monetary Penalty (CMP) per violation.

f) Civil assessment of up to three times amount of kickback (OIG, 2020).

VIII. Civil Monetary Penalties (CMP) Law 42 CFR § 1003.103:

A. Authorizes the imposition of CMPs against an entity that engages in activities including, but not limited to knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any. The OIG may impose a penalty of not more than:

1. $2,000 for each wrongful act occurring before January 1, 1997.

2. $10,000 for each wrongful act occurring on or after January 1, 1997.

3. The OIG may impose a penalty of not more than $15,000 for each person with respect to whom a determination was made that false or misleading information was given under §1003.102(b)(4) (gpo, 2020).

V. The Exclusion Provision 42 U.S. C. § 1320a- 7, § 1128, Social Security Act:

A. Gives the HHS-OIG the authority to exclude individuals from participating in federal health care programs, such as Medicare and Medicaid, for various reasons, and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties. There are two types of Exclusions: Mandatory and Permissive Exclusions (OIG, 2021).

1. Mandatory exclusion reasons are :

a) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, State Children's Health Insurance Program (SCRIP), or other State health care programs.

b) Patient abuse or neglect.

c) Felony convictions for other healthcare-related fraud, theft, or other financial misconduct.

d) Felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

1. Mandatory Exclusion Penalties are.

MANDATORY EXCLUSIONS PENALTIES		
Social Security Act	**42 USC §**	**Amendment**
1128(a)(1)	1320a-7(a)(1)	Conviction of program-related crimes. Minimum Period: 5 years.
1128(a)(2)	1320a-7(a)(2)	Conviction relating to patient abuse or neglect. Minimum Period: 5 years.

1128(a)(3)	1320a-7(a)(3)	Felony conviction relating to health care fraud. Minimum Period: 5 years.
1128(a)(4)	1320a-7(a)(4)	Felony conviction relating to controlled substance. Minimum Period: 5 years.
1128(c)(3)(G)(i)	1320a-7(c)(3)(G)(i)	Conviction of two mandatory exclusion offenses. Minimum Period: 10 years.
1128(c)(3)(G)(ii)	1320a-7(c)(3)(G)(ii)	Conviction on 3 or more occasions of mandatory exclusion offenses. Permanent Exclusion.

2. Permissive exclusion Reasons are:

a) Convictions related to health care fraud other than Medicare or a State health program, fraud in a program (other than a health care program) funded by any federal, state or local government agency.

b) Misdemeanor convictions relating to the unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

c) Suspension, revocation, or surrender of a license to provide health care for reasons of unnecessary or substandard services.

d) Submission of false or fraudulent claims to a federal health care program.

e) Engaging in unlawful kickback arrangements.

f) Defaulting on a health education loan or scholarship obligations.

g) Controlling a sanctioned entity as an owner, officer, or managing employee.

4. Permissive Exclusion Penalties:

PERMISSIVE EXCLUSION PENALTIES ARE:		
Social Security Act	**42 USC §**	**Amendment**
1128(b)(1)(A)	1320a-7(b)(1)(A)	Misdemeanor conviction relating to health care fraud. Baseline Period: 3 years.
1128(b)(1)(B)	1320a-7(b)(1)(B)	Conviction relating to fraud in non- health care programs. Baseline Period: 3 years.
1128(b)(2)	1320a-7(b)(2)	Conviction relating to obstruction of an investigation. Baseline Period: 3 years.
1128(b)(3)	1320a-7(b)(3)	Misdemeanor conviction relating to controlled substance. Baseline Period: 3 years.
1128(b)(4)	1320a-7(b)(4)	License revocation or suspension. Minimum Period: No less than the period imposed by the state licensing authority.
1128(b)(12)	1320a-7(b)(12)	Failure to grant immediate access. Minimum Period: None
1128(b)(13)	1320a-7(b)(13)	Failure to take corrective action. Minimum Period: None
1128(b)(14)	1320a-7(b)(14)	Default on health education loan or scholarship obligations. Minimum Period: Until default has been cured or obligations have been resolved to Public Health Service's (PHS) satisfaction.
1128(b)(15)	1320a-7(b)(15)	Individuals controlling a sanctioned entity. Minimum Period: Same period as entity.
1128(b)(16)	1320a-7(b)(16)	Making false statement or mis-representations of material fact. Minimum period: None. The effective date for this new provision is the date of enactment, March 23, 2010.

1156	1320c-5	Failure to meet statutory obligations of practitioners and providers to provide' medically necessary services meeting professionally recognized standards of health care (Peer Review Organization (PRO) findings). Minimum Period: 1 year.
1128(b)(6)	1320a-7(b)(6)	Claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, or failure of an HMO to furnish medically necessary services. Minimum Period: 1 year.
1128(b)(7)	1320a-7(b)(7)	Fraud, kickbacks, and other prohibited activities. Minimum Period: None.
1128(b)(8)	1320a-7(b)(8)	Entities controlled by a sanctioned individual. Minimum Period: Same as length of individual's exclusion.
1128(b)(8)(A)	1320a-7(b)(8)(A)	Entities controlled by a family or household member of an excluded individual and where there has been a transfer of ownership/ control. Minimum Period: Same as length of individual's exclusion.
1128(b)(9), (10), and (11)	1320a-7(b)(9), (10), and (11)	Failure to disclose required information, supply requested information on subcontractors and suppliers; or supply payment information. Minimum Period: None

5. **Reinstatement of Excluded Entities and Individuals:** This is not automatic at the end of an exclusion period. To apply for reinstatement you must send a written request to:

HHS, OIG,
Attn: Exclusions
P.O. Box 23871
Washington, DC 20026
Fax: (202) 691-2298

The OIG will then provide Statement and Authorization forms that you must complete, and have notarized and returned. Then the OIG's final decision on reinstatement will be sent to you in approximately 120 days. Excluded providers may begin the process of reinstatement 90 days before the end of an exclusion period, and premature requests will not be considered. If reinstatement is denied, the excluded party is eligible to reapply after one year.

VI. The Stark Law (aka) the Physician Referral Law 42 U.S.C. § 1395nn, § 1877:

A. The Physician Self-Referral Law of the Social Security Act which is commonly referred to as the Stark law prohibits physicians from referring patients to receive "Designated Health Services" payable by Medicare or Medicaid from entities with which the physician ,or an immediate family member has a financial relationship, unless an exception applies by law (OIG, 2020).

B. Examples of designated health services monitored under the Stark Law:

1. Clinical laboratory services.

2. Physical therapy, occupational therapy, and outpatient speech-language pathology services.

3. Radiology and certain other imaging services.

4. Radiation therapy services and supplies.

5. Durable medical equipment and supplies.

6. Parenteral and enteral nutrients, equipment, and supplies.

7. Prosthetics, orthotics, and prosthetic devices and supplies.

8. Home health services.

9. Outpatient prescription drugs.

10. Inpatient and outpatient hospital services.

C. Stark Law Penalties are:

1. Overpayment/refund obligation.

2. False Claims Act liability.

3. Civil monetary penalties and program exclusion for knowing violations.

4. Potential $15,000 CMP for each service.

5. Civil assessment of up to three times the amount claimed.

XI. Health Insurance Portability and Accountability Act; Pub. L. 104- 191, 110 Stat.:

A. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information. Collectively these are known as the Administrative Simplification provisions, that are based on the HIPAA Privacy Rule, HIPAA Security Rule, HIPAA Breach Notification Rule, and the HIPAA Omnibus Rule (CG, 2021), and there are both criminal and civil penalties for HIPAA violations (OIG, 2020).

1. Scenarios that violate the HIPAA are (Yourdictionary, 2020) quoted as follows:

a) Telling friends or relatives about patients in the hospital.

b) Discussing private health information in public areas of the hospital, including the lobby of a hospital, an elevator or the cafeteria.

c) Discussing private health information over the phone in a public area.

d) Not logging off your computer or a computer system that contains private health information.

e) HIPAA regulations for "need to know" include: The security guard in a healthcare institution needs to know the name and room number of patients to guide visitors. This is allowed; but, any other information, such as diagnosis or treatment, is not to be disclosed.

f) HIPAA regulations for "need to know" include: A nurse needs access to private health information for the patients in his/her unit but not for any patients that are not in that unit.

g) HIPPA regulations for "minimum necessary" include: A health insurance company will need information about the number of visits the customer had; but isn't allowed to view the entire patient history.

h) Allowing members of the media to interview a patient in a substance abuse facility.

i) Including private health information in an email sent over the Internet.

j) Releasing information about minors without the consent of a parent or guardian.

B. Criminal penalties for HIPAA (Indest, 2014):

1. In June 2005, the U.S. Department of Justice (DOJ) clarified who can be held criminally liable under HIPAA. Covered entities and specified individuals, who " knowingly" obtain or disclose individually identifiable health information in violation of the Administrative Simplification Regulations face a fine of up to $50,000, as well as imprisonment up to one year.

2. Offenses committed under false pretenses allow penalties to be increased to a $100,000 fine, with up to five years in prison. Finally, offenses committed with the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain or malicious harm permit fines of $250,000, and imprisonment for up to 10 years.

C. Civil Penalties for HIPAA (Indest, 2014) as follows**:**

HIPAA VIOLATIONS	CIVIL MINIMUM PENALTIES	CIVIL MAXIMUM PENALTIES
Individual did not know that he/she violated HIPAA and by exercising reasonable diligence, would not have known.	$100 per violation, with an annual maximum of $25,000 for repeat violations. Note: This is the maximum penalty that can be imposed by the State Attorney General regardless of the violation.	$50,000 per violation, with an annual maximum of $1.5 million.
HIPAA violation due to reasonable cause and not due to willful neglect.	$1,000 per violation, with an annual maximum of $100,000 for repeat violations.	$50,000 per violation, with an annual maximum of $1.5 million.
HIPAA violation due to willful neglect but violation is corrected within the required time period.	$10,000 per violation, with an annual maximum of $250,000 for repeat violations.	$50,000 per violation, with an annual maximum of $1.5 million.
HIPAA violation due to willful neglect and is not corrected.	$50,000 per violation, with an annual maximum of $1.5 million.	$50,000 per violation, with an annual maximum of $1.5 million.

XII. Occupational Safety and Health Act 29 U.S.C. § 651 (1970):

A. Under this law the Safety Officer may exercise emergency authority to monitor and assess hazardous and unsafe situations to immediately correct any unsafe problems throughout the hospital. Maintaining a safe workplace environment is the

responsibility of the Safety Officer with the coordination of all areas of the hospital at all levels management on a continuous basis.

B. Civil penalties for OHSA (OSHA, 2020) :

TYPE OF OHSA VIOLATIONS	OHSA MINIMUM PENALTIES	OHSA MAXIMUM PENALTIES
Serious	$964 Per violation	$13,494 per violation
Other-Than-Serious	$0 per violation	$13,494 per violation
Willful or Repeated	$9,639 per violation	$134,937 per violation
Posting Requirements	$0 per violation	$13,494 per violation
Failure to Abate	NIA	$13,494 per day unabated beyond the abatement date [generally limited to 30 days maximum]

4.5 THE JOINT COMMISSION PREPARATION

Inspection time by the Joint Commission (JC) creates a great deal of anxiety throughout the entire hospital, and from the AARC leadership institute I researched, "Are You Joint Commission Ready?" by Cheryl Hoerr, MBA, RRT, FAARC, of Phelps County Regional Medical Center, Keith Roberts, MBA, RRT, CPFT, of Rush University Medical Center, and Julie Jackson, BAS, RRT-ACCS, RCP, of UnityPoint Health-Des Moines, along with my personal experiences I will share on how to prepare for the Joint Commission inspection. As a first-time RT supervisor with little or no prior supervisory experience, relax and consider your first JC inspection a learning opportunity and a chance to impress the upper management, and if you get gigged in the JC inspection for something, you are allowed to make correction(s) and you only need to correct the issue and let the JC know.

Control your anxiety level in the RT department, do not get short tempered with your RT staff, and be cool and calm. It is your first JC inspection and it is understood you may be a little hyped up. Just relax, and systematically check everything you will need to check to prepare for the JC inspection, and delegate some tasks to the RT staff to check certain areas before you check those areas yourself (e.g. the oxygen tanks, ventilator orders from the past three months), and make preparing for the JC inspection a joint team effort in the RT department.

Traditionally the JC will inspect the inside of the RT department and this can include but is not limited to inspecting all of the RT department's administrative documentation and records with the appropriate updates and medical staff approval signatures (Robert, 2018), such as the RT department policy and procedure manuals, RT equipment training records, competency skill check list, safety manuals and records, proof of credentials and licenses, and BLSC and ACLS certifications. There should be Infection control training records that indicate procedures with step-by-step processing instructions for gross cleaning, disinfectant cleaning and sterilization to ensure the proper reprocessing of RT equipment (CDC, 2016) (Hoerr, 2018).

The inspectors have been known to walk into the ICU and check ventilator orders against the ventilator start time and the date and time the Ventilator order was written because it is not proper for the ventilator start time to be before the date of the ventilator order (Hoerr, 2018). The ICU can become very busy and a doctor sometimes will verbally call out ventilator orders for the patient with the intentions of writing the ventilator order(s) a little later, and if the doctor gets sidetracked and does not write that order shortly, then the RT order becomes a verbal order that the Respiratory Therapist needs to chart as a verbal order immediately, then follow-up with the doctor for a written ventilator order as soon as possible with the correct start time.

When I first took over the San Francisco VA Medical Center RT department I got the hospital computer programmer to configure the system so an Respiratory Therapist could submit an unsigned verbal doctor's order into the computer system, then when the next time the doctor logs on to the computer he or she will be flagged to sign the RT order(s), and I had that information configured so it would appear in the RT end-of- shift report so the Respiratory Therapists will know on a continuous basis which RT order(s) has not been signed, and they can follow up with the doctor to get the RT order(s) signed. The JC will look into ventilator orders and when they immediately show up the RT supervisor should task one of the Respiratory Therapist to make a run through to check all the ventilator orders to avoid a JC gig.

The JC inspectors will conduct visual safety inspections of the RT department area, RT equipment and storage, medical compressed gas tanks and storage. You can review the in-house JC standards manual or contact the JC standards department, or use google to find out the JC standards are for a certain issue, you can also contact other fellow experienced RT supervisors in your area, or you can contact experience RT supervisors through the AARC (Jackson, 2018).

The JC really looks forward to questioning RT staff and an RT supervisor should prepare their RT staff for potential questioning (Robert, 2018). For example, the JC surveyor might ask a staff member, "What does the acronym R.A.C.E. stand for?" (Rescue, Alarm, Confine, Extinguish/Evacuate). The questioning could be generic to the RT department or more specific to an RT issue, a new first-time RT supervisor should contact a more experienced RT supervisor in their area, or through the AARC to get an idea of what kind of questioning the JC might ask.

Another type of Joint Commission inspection is called the "Patient Tracer Methodology," that is when the JC inspectors do not come into the RT department for an inspection, and the JC surveyors will go into the medical records of several RT patients, that are still in the hospital during the inspection or have been discharged, and inspect the medical records for the Respiratory Therapy care that those patients has received. When I was a first-time promoted RT supervisor with no prior supervisory experience, I had 90 days to prepare for my first JC inspection that I thought was going to be a traditional JC inspection.

In the first week of being the Chief of RT I started creating a boiler plate comprehensive RT template to limit the use of free texting RT charting notes as much as possible and to have all RT notes templated as much as possible. So, I would not have to worry about a staff Respiratory Therapist's command of the English language, and their ability to type when charting RT notes. The reason for the development of the comprehensive RT template was to increase the amount of RT charting notes by making RT charting easier and produce a higher quality of RT notes, based on our RT policies and procedures and RT equipment used in the department.

I was not expecting the JC to come in and inspect with the patient tracer methodology, and by the time the JC arrived to inspect my RT department I had two and a half months of standardized easy to read templated RT notes, and the initiative to create the comprehensive RT template at the beginning of my Chief of RT appointment paid off because, the JC found no gigs with the patient tracer method while I was the interim Chief of RT (see Appendix M).

A first-time inexperienced RT supervisor should meet with the Hospital's Compliance Officer (HCO) prior to their first JC inspection as a preparation resource because the HCO as a resource has immediate direct contact with the Hospital Director (CEO) and the Executives in the C-suite, and a great

deal of what the JC will inspect throughout the hospital is the Hospital's Compliance Officer job to make sure everybody is in compliance with. According to the JC website the Joint Commission's mission is to ensure healthcare organizations are "providing safe and effective care of the highest quality and value" (AARC, 2018), and that is what the HCO job is. The JC surveyor's mission is to check for compliance when they inspect, and if you are running out of time, or are being met with some resistance to make a correction for the preparation for a JC inspection, then let the HCO know at the same time as you present the issue to upper management to get the matter resolved.

4.6 RESPIRATORY THERAPY AND PERFORMANCE MEASURES

First-time RT supervisors should be aware that performance measures are monitored throughout the year in a healthcare organization and every year there is a fiscal year annual performance plan and report from the U.S. Department of Health and Human Services (HHS). The performance measures are aligned with strategic goals and strategic objectives that also involve Respiratory Therapy care (HHS, 2020). The five strategic goals overview for 2018 through 2022 are as quoted:

- **"Goal 1:** Reform, Strengthen, and Modernize the Nation's Health Care System.
- **Goal 2:** Protect the Health of Americans Where They Live, Learn, Work, and Play.
- **Goal 3:** Strengthen the Economic and Social Well-Being of Americans across the Lifespan.
- **Goal 4:** Foster Sound, Sustained Advances in the Sciences.
- **Goal 5:** Promote Effective and Efficient Management and Stewardship."

The HHS performance measures affect healthcare organizations that accept Medicaid and Medicare funds and certain performance measures that are not complied with could cause a loss of those funds from the HHS Center of Medicaid and Medicare Services (CMS). For instance,

under the Affordable Care Act also known as Obama Care enacted on March 23, 2010 hospitals are mandated to improve their service to patients or possibly lose Medicaid and Medicare funds (Torrey, 2020). There are other performance metrics that Respiratory Therapy affects that include but not limited to length of stay (LOS), budget issues, risk management, associated infection control and communication about medications that are monitored by upper management that a first-time RT supervisor should be aware of.

First-time RT supervisors should be aware of the Agency for Healthcare Research and Quality (AHRQ) that is a Federal Agency established to help improve safety and quality in the United States healthcare system (AHRQ, 2020). The AARC has provided an article by Lisa Houle, Director of cardiopulmonary services at Baptist Health La Grange that has provided an important take-a-way that the "patient experience" is connected to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey mandated by the federal government. The HCAHPS survey has no specific questions related to Respiratory Therapy however, the survey has defined domains, or groups of questions, that respiratory therapy impacts (AARC12, 2020), and that is the same situation for other performance measures.

For example, in the domain that has questions involving medication and education of side effects this is related to patients communications, and in the response in a survey the patient may not differentiate nurses, doctors and other allied licensed clinical professionals from each other. Another domain of questioning involves the environment with respect to cleanliness and quietness and Respiratory Therapy has an impact in many parts of the patient experience in the survey questioning (AARC12). When it comes to patient satisfaction whether respiratory therapy is specific mentioned in a survey or not we need to understand that RT is involved (AARC12).

The Department of Veterans Affairs does not receive CMS funding, and also has a fiscal year Annual Performance Plan and Report that consists of more than 120 performance metrics across the Department (VA, 2020, p.IV). The strategic goals are as quoted,

- "**Strategic Goal 1:** Veterans choose VA for easy access, greater choices, and clear information to make informed decisions.
- **Strategic Goal 2:** Veterans receive highly reliable and integrated care, support and excellent customer service that emphasizes their well-being and independence throughout their life journey.
- **Strategic Goal 3:** Veterans trust VA to be consistently accountable and transparent.
- **Strategic Goal 4:** VA will transform business operations by modernizing systems and focusing resources more efficiently to be competitive and to provide world-class customer service to Veterans and its employees."

When a first-time RT supervisor takes over an RT department he or she should research the goals of the performance measures as soon as possible to have an idea of what upper management is concerned about and manage the RT department accordingly.

4.7 RESPIRATORY THERAPY DISASTER PREPARATION

When you first take over a Respiratory Therapy department as a first-time inexperienced RT supervisor, the last thing on your mind is going to be preparing for a disaster, but eventually the topic will come up and you will have to coordinate with the Director of the Emergency Management department. The AARC has offered tips on how to deal with a disaster from Sharon Armstead, EMBA, RRT, clinical assistant professor at Texas State University that involves (Armstead, 2019):

I. **Creating the employee phone callback:** This can be by phone or text, and the Staff needs to understand the importance of a disaster callback list, and they should be asked, "how long will it take for you to come in?" and note when they were contacted and their correct time of arrival.

II. **Be prepared for other roles:** In a disaster, when Staff comes in they may be under the Hospital Incident Command System (HICS) authority, and you may be place in roles other than a Respiratory Therapist if necessary (e.g. helping with transports).

III. **Hospital Incident Command System (HICS):** The RT staff should be trained on a consistent basis on the HICS, and understand the difference between:

   A. **Internal disasters:** This happens in the interior of the hospital (e.g. Building structural collapse, Utility loss, Explosions, Fires, Floods, Chemical spills).

   B. **External disasters:** Happens outside of the facility, and can have an impact to the facility (e.g. Mass Casualty Incidents, Severe Weather, Motor Vehicle Accidents, Civil Disturbance, Industrial Emergencies, Terrorist Attack, and Earthquakes). There should be a multi Code Triage response system develop. For example, starting with level 1 for staff alert ,and level 2 that impacts the staff and so forth.

   C. **Staying connected:** Disasters may involve the community of your hospital, and from personal experience as the Chief of RT in the San Francisco VA Medical Center for 10 years the occasional earthquake was a perfect example of why it is absolutely necessary for preparation with community partners.

   D. **Lessons learned:** Over the course of my RT career I have seen several emergency crisis, and it was always a priority to learn from each one. Respiratory Therapists are first responders and must always be prepared to be impacted by an emergency.

Especially, if there is a need for oxygen and/or air supply, or you may need to activate the oxygen shutdown plan (Armstead, 2019).

From my personal experience with electrical power failures and the earthquake prone city of San Francisco, CA not only you will need to activate the oxygen Shutdown system, you should also be able to seal off a hospital unit (e.g. the ICU) and backfill it with oxygen if the central bulk oxygen supply system has been compromised. The RT department and the Engineering service should have a separate set of "male double end quick connect oxygen hoses" with oxygen "H" tanks on standby to be connected. There is far more information a new RT supervisor needs to know to be prepared for an emergency. For example, the separation and storage of specific equipment designated for the advance preparation of an emergency/disaster, and it is the RT supervisor's responsibility to research emergency preparedness and be prepared.

4.8 INFORMATION SYSTEMS FOR RESPIRATORY THERAPY

As a first-time new RT supervisor taking over a new respiratory therapy department you should become familiar with the hospital's computer system software that is used in the RT department, and he or she should be familiar with the Microsoft Office suite (e.g. Word and Excel), and then make an appointment with the hospital's computer programmer as soon as possible even if you do not think you need it at the moment, because it is going to take some time to get assigned a block of time with the hospital's computer programmer, and by then later there is a pretty good chance you will need his or her services to configure any system reports you may need, such as:

I **Respiratory Therapy Charting Templates:** The RT supervisor should use RT templates to chart all RT notes as much as possible, to limit the use of free texting RT charting notes, to make RT charting easier and produce a higher quality of RT notes, so you won't have to worry about a Respiratory Therapist's command of the English language, and their ability to type. The reason this is important is because you never know when the Joint Commission will come to inspect the RT department with traditional method or the patient tracer methodology or both inspection methods.

The Joint Commission on occasion does an RT patient tracer method to inspect the RT department. Whereas they select several RT patients and inspect their medical records from the time they were admitted to the time they are still in the hospital during the inspection, or to the time of patient discharge, and you would like the RT notes to be standardized and easy to read for the Joint Commission inspectors.

II. **Automated Shift Reports:** The RT supervisor can have the computer programmer configure an automated respiratory therapy shift report. So, at the end of the shift for each patient care area the outgoing Respiratory Therapist can run a change of shift report for a specific clinical area with all the RT patients, and the RT doctor's orders only.

III. **Automated RT Charge Sheets:** The RT supervisor should investigate the computer system to see if RT charges can be entered into the system when the respiratory therapist charts on the doctor's RT order, so the Respiratory Therapist will not have to submit the RT charges at the end of the day, to prevent any of the RT charges from being missed.

IV. **RT Report Storage Retainment:** The new RT supervisor should have the computer system programmed to retain all shift reports for a certain amount of time in case there may

be a need to query patient healthcare information for a patient care or administrative investigation.

V. **Administrative files:** One of the first things that should be done when a new RT supervisor takes over an RT department, and that is to create a digital (electronic) folder on all the staff, and keep an electronic copy of all hardcopy documents as much as possible.

VI. **Internal Interoperability:** The RT supervisor should check with the computer programmer to see if there are program changes that can be made to improve the RT system interoperability. How intuitive or counterintuitive the software is can make a great deal of difference in the functionality of interoperability for users. Improving internal interoperability is one of the best strategies you can use for the benefit of patient care and safety, and better workflow for physicians and other allied healthcare practitioners, that would like an electronic health records system that works with their workflow and not against it (Rose, 2018).

Securing an improvement in internal interoperability with the computer programmer allows you to access data easier and as fast as possible to analyze and make the best patient care decisions. This also involves being able to quickly query patient's healthcare information for investigations and research. Improvements in internal interoperability could also involve anything from something as simple as configuring software to reduce the number of times you may have to click the mouse to access data, to something as complicated as integrating components to configure an electronic information system network (Rose, 2018).

VII. **The legislative history of healthcare interoperability:** The push to initially promote interoperability was started with the Office of the National Coordinator for Health Information Technology that was established on April 24, 2004 by President George W

Bush' s Executive Order number 13335. Then on February 17, 2009 President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111-5) that included 49 billion dollars in discretionary spending to support and promote the adoption of electronic health records (EHRs) (Goldstein, 2010). As part of the ARRA, Title XIII was enacted with the subtitle, Health Information Technology for Economic and Clinical Health Act (HITECH) on February 17, 2009 to support the idea and development of EHRs. In 2011, Interoperability programs were established to promote the "meaningful use" in healthcare organizations, that was rolled out in three stages as quoted by the CMS:

- **Stage 1:** Set the foundation for the Promoting Interoperability Programs by establishing requirements for the electronic capture of clinical data, including providing patients with electronic copies of health information.
- **Stage 2:** Expanded upon the Stage 1 criteria with a focus on advancing clinical processes and ensuring that the meaningful use of EHRs supported the aims and priorities of the National Quality Strategy. Stage two criteria encouraged the use of Certified Electronic Health Record Technology (CEHRT) for continuous quality improvement at the point of care and the exchange of information in the most structured format possible.
- **Stage 3:** In October 2015, CMS released a final rule that established Stage three in 2017 and beyond, which focuses on using CEHRT to improve health outcomes. In addition, this rule modified Stage two to ease reporting requirements and align with other CMS programs" (CMS, 2019).

Meaningful use is a nationwide goal to improve the interoperability of electronic health records for: (1) Improving quality, safety, efficiency, and reducing health disparities; (2) Engage

patients and families in their health; (3) Improve care coordination; (4) Improve population and public health; (5) Ensure adequate privacy and security protection for personal health information (CDC, 2017).

4.9 RESPIRATORY THERAPY WITH TELEHEALTH

This is a very dynamic time to be part of the Respiratory Therapy profession, and the COVID19 crisis has exposed how important Respiratory Therapists are and the AARC is currently lobbying the Federal Government so Respiratory Therapists can provide Respiratory Therapy services via Telehealth. The laws that are pending and being lobbied for by the AARC are quoted as follows:

I. HR Bill 2508, also known as the BREATHE Act (Better Respiration through Expanding Access to Tele-Health Act) (Congress, 2020) to establish a 3-year pilot program to evaluate the benefit of respiratory therapists providing RT service via telehealth under the Medicare program. The bill has bipartisan support by Rep Earl Carter (R-Ga), Rep TJ Cox (D-Calif), Rep Mike Kelly (R-Pa) and Rep Mike Thompson (D-Calif) (RT, 2019).

II. "The CONNECT Act (Creating Opportunities Now for Necessary and Effective Care Technologies – HR 4932 has 68 cosponsors, and the S.2741 - Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019 that has 46 cosponsors" (Congress.gov, 2020) are the only bills that allow Respiratory Therapists to provide telehealth services moving forward (AARC10, 2020).

Providing RT services via telehealth is a new patient care delivery model that is going to be under the supervision of an RT supervisor that will help the RT profession grow. The new laws will allow Respiratory Therapists the opportunity to work either part-time or under contract in a physician's offices and clinics (AARC10, 2020). All RT

supervisors with or without experienced will have to be involved in the development of the new Respiratory Therapy services program via telehealth. As a resource to implement a new RT telehealth program an RT supervisor should be familiar with the professional telehealth associations, such as:

III. **American Telemedicine Association (ATA) Practice Guidelines,** is information for new telehealth programs (see Appendix N) (Ferguson, 2012) .

IV. **American Health Information Management Association (AHIMA),** that provides a Telemedicine Toolkit handbook, that provides assistance to start, maintain and stay compliant with a telehealth program (AHIMA, 2017).

4.10 RESPIRATORY THERAPY EQUIPMENT MANAGEMENT

At some point as an RT supervisor you are going to have to engage with the Chief of Acquisition and Material Management to purchase RT equipment. You should make an attempt to build a relationship with him or her before you actually need something. Find out what is your allowable budget as soon as possible, so if you feel the budget is not enough to meet the needs of the RT department, you can let your RT Medical Director know so he or she can support you when you start to negotiate the matter through the hospital's administration. Beware, sometimes other hospital services get everything they want at the expense of shortchanging other departments, such as the RT department.

A first-time inexperience Respiratory Therapy supervisor will be required to negotiate with vendors for capital and non-capital purchases. It takes hundreds of thousands of dollars to run a Respiratory Therapy department annually, and some of that money is recommended for approval by an RT supervisor. For this reason, it is important that an immediate on-demand

emergent administrative training program like this one be provided for first-time inexperienced RT supervisors.

A vendor is well trained on how to become your friend and that is not because he or she wants to actually be your friend, it is part of the salesmen strategy to secure a purchase order, and they will try to eliminate their competition by telling you. They are the only company you will need for the type equipment they are selling, and this technique will stop you from establishing relationships with other vendors that could be beneficial to the RT department and RT patients. Consider buying the same product from more than one vendors if possible so they can compete against each other to your advantage.

For instance, if you have 18 rooms in the Intensive Care Unit (ICU) some RT Chiefs will say in the decision making process before the COVID19 crisis, "We don't need to buy 18 ventilators because we never have 18 ventilators running at one time," an RT supervisor should always look to expect the unexpected and the COVID19 crisis is a perfect example of that. Some RT Chiefs will say, "Lets buy 18 ventilators from the same company so we will always have spare parts from one ventilator to another." When purchasing ventilators they all ventilate and you have ventilator service contracts to deal with breakdowns, but there are some differences in ventilator modes and features from one ventilator company to another that can benefit an RT patient.

Therefore, if you are going to buy 18 ventilators for an 18 room ICU it is a good idea to consider buying 50 percent (half) of them from one ventilator company and the other half from another company, or buy the majority of ventilators from one company (e.g. 13 ventilators) and the remaining five ventilators from another company so you can have a wider variety of

ventilator features for better patient care, and still have some competition going between ventilator vendors.

As a first time RT supervisor you will be at the crossroads to make many capitol purchases for critical care RT equipment, and there are many factors about ventilator(s)s and other RT medical equipment(s) that you will only find out by the experience you do not have as a new first-time supervisor that can include, but is not limited to,

I. The breakdown rate of one ventilator over another, that can be determined by contacting someone who has used or is using a certain ventilator.

II. Ease of getting replacement parts on a consistent basis.

III. Some ventilators have internal backup air-compressors without a built in backup batteries power system, and you should ask about that issue question before the purchase has been made.

IV. Ease of use for the RT staff,

V. What should you save money on versus what should you spend a little more money on to get higher quality equipment(s) for the RT department?

VI. Do not make an RT purchase based on your friendship with a vendor.

VII. Find out what your staff thinks about a particular ventilator you are considering to buy because they are the ones that are going to have to use it.

VIII. Remember the market share of the ventilator company or other RT equipment company you are thinking about dealing with, does not necessarily mean they have the best or worst ventilator or other RT equipment(s) on the markets, because there are many factors that play into that and you should investigate those factors to make sure you are making a good purchase.

IX. There are many more issues to be considered, and as a first-time inexperience RT supervisor you should research them.

Never take a vendor's word based on a future availability date to buy ventilators or any other type of medical equipment if all the component(s) (parts) to operate that RT equipment are not immediately available with the initial purchase. The vendor may tell you an availability date for an RT equipment part that is sooner than the date that the part will actually be available, and you could end up waiting for that RT equipment part for a much longer time than what you would appreciate.

For example, back in 2002 at the San Francisco VA Medical Center when I was the Assistant Chief of RT, the Chief of the RT department purchased 18 Ventilators for the 18 bed ICU, and I noticed at the last minute he did not buy the internal back up air-compressor that goes with the ventilators, and his reasoning was because we could get compressed air from the wall connection. I objected to that reasoning, and informed the RT Chief that we live in an earthquake prone area and you never know when the bulk central medical gas lines might become compromised, and we will need the backup air compressors that go with the ventilators. I was then over-ruled by the RT department Chief, and I went to the RT Medical Director and he over-ruled the RT Chief and the backup internal air-compressors were purchased, then I found out that the internal backup air compressor were not available with the delivery of the new ventilators, and the ventilator salesman gave us a very convincing pitch that the internal backup air-compressors would be arriving soon.

Shortly, after that the RT Chief at the time resigned, and I was appointed as the interim Chief of the RT department, the internal backup air-compressors did not arrive on the date that the ventilator vendor gave us, and I had to deal with that ventilator vendor to get those

internal backup air compressors as soon as possible, and that took longer then what we had anticipated on agreement, and it took much longer than what I appreciated out of fear of something catastrophic happening in the worst earthquake prone city in the United States.

Honestly, if the vendor had told me up-front how long I had to wait for those internal backup air compressors I would have went with another ventilator company if I was the deciding RT Chief on the purchase at the time. Another issue that caught me off guard was I did not inquire if the emergency battery backup system on the ventilators worked with the internal backup air compressors because I thought that was a standard feature on all ventilators because I had seen built in battery backup systems that activated the internal air compressor in older ventilator models. If I had known the built in backup battery power system did not activate the internal air compressors before the ventilator purchase was made I would have went to the RT Medical Director who was an Anesthesiologist and tried to stop the purchase because San Francisco was an earthquake prone city. It was a lesson learned as a rookie first-time RT supervisor that I am sharing, and if there was an immediate on-demand emergent administrative training program like this one that predicament could have been avoided.

There is far more a new first-time RT supervisor will need to know about purchasing RT equipment(s), and I recommend a first-time inexperience RT supervisor conduct some research with more experienced people in the RT profession on how to purchase RT equipment before they actually need to make any purchases big or small.

4.11 CONFLICT RESOLUTION

From the AARC Leadership Institute, Leadership and Team Building course offered by Cheryl A Hoerr, MBA, RRT, CPFT, FAARC (AARC8, 2020). Conflict can occur between two

or more individuals who have disagreement (s) or opposing view(s) for a variety of reasons, that can be minor or they can escalate into all-out warfare. Conflict is inevitable and will eventually happen when two or more people work in the same area. However, conflict is not a bad thing because it allows for differences of opinion and alternate approaches to be heard, and if conflict is managed successfully it can lead to better ideas to solve problems. On the other hand, if conflict is not dealt with in the correct manner it can have an adverse effect on the employee's morale and self-esteem in the workplace. There are conflict resolution strategies to be consider, such as:

I. **Accommodation strategy:** This is used when a person on one side of the conflict gives up to maintain a good relationship with the other person.

II. **Avoidance strategy:** Used when both parties ignore the issue and the relationship because it not considered important. However, the use of this strategy is because people are uncomfortable with conflict and would like to see the issue just go away, but this strategy only works for a limited period of time before a conflict festers and resentment, and hostilities boil over.

III. **Competition strategy:** This is a "win/lose" strategy where one person goes all out to "win" the conflict. The winner is usually a highly assertive personality, when the outcome is important to one or both parties, and one person or the other is willing to sacrifice their relationship with each other over the conflict. However, you do not have to be hostile or angry when using this strategy, you have to want to win at all cost.

IV. **Compromise strategy:** Is a "lose/lose" strategy when neither party gets exactly what they want, and is of medium importance for the outcome and the future relationship.

This strategy is rarely used, and is used for circumstances, such as contract negotiations and negative decisions for pay cuts or layoffs.

V. **Collaboration strategy:** This is the preferred conflict resolution strategy because it leads to a "win/win" situation and satisfies all parties. It is best use when multiple parties integrate ideas. The disadvantage of this type of negotiation is the significant time commitment needed that may not be available in all conflict situations. This strategy is valued because the outcome and future relationships between the conflicting parties are of critical importance, and the goal is for everyone to be satisfied with a win/win outcome.

4.12 DISCIPLINARY ACTIONS

In the real world from firsthand experience the first thing you should ask yourself when considering any type of disciplinary action is, “do you have an alternative option to deal with the problem before you go through the contentious process of a disciplinary action?” Because if your RT staff think that you only make your worth as a RT supervisor is when you are writing someone up for a disciplinary action against them every chance you get, nobody is going to want to work for you, or extend themselves for you when you may need them. There may be times when you must take a disciplinary action and have no other choice. However, first-time RT supervisors should know that upper management will think positively of them for being able to manage problems or change the negative behavior of an employee without having to take a disciplinary action within reason, even if you have the right to take a disciplinary action consider how much allowable discretion you have over the matter and discussion that with your immediate supervisor and your service chief and the employee relations specialist in human resources before you make a recommendation for a disciplinary action.

After ten years as the Chief of Respiratory Therapy, when I look back on all the disciplinary actions I took over the years. There were a percentage of them that was not worth the contentious disciplinary process I went through to handle the matter, considering I could have used other options to get an employee to change their behavior without taking a disciplinary action, but there were times as a first-time RT supervisor I was too nervous and afraid of losing my job and naïve to use the discretion that was available to me, and nobody gave me that insight with an on-demand emergent administrative training in advance as part of the hospital culture.

If you are constantly solving problems with disciplinary actions then you are not thinking ahead of the game to prevent problems, and that is an indication of your inability to manage problems. RT supervisors need to be able to manage a RT department without always having problems that lead to a disciplinary action and knowing when to take a disciplinary action is just as important as knowing when not too because, frontline clinical supervisors from one section are being compared to other front line supervisors of other clinical sections in the hospital, and if upper management notices that one department is constantly involved with disciplinary actions and Union grievances the hospital administration will start to look at the supervisors over that section, and every so often by that time a discussion to consider replacement has already been started.

Handling a disciplinary action is one of the most difficult duties for a first-time RT supervisor, and knowing when to choose a disciplinary battle is something that is not taught in a clinical RT program, but rather it is a talent that is acquired over time with experience. A first-time RT supervisor without prior experience should be given immediate on-demand emergent administrative training to teach them how to choose a workplace battle wisely because every

time an RT supervisor considers a disciplinary action, even if they have the right to do so, there are always other options to be considered before you settle on an official disciplinary action.

Most first-time RT supervisors without prior experience are very nervous and are afraid of losing their job and are reluctant to use discretion or may not be aware of the discretion they have as an RT supervisor to handle problems, that would be used by a more experienced RT supervisor. As part of an immediate emergent administrative training program management should teach an inexperience first-time RT supervisors the tips on how to choose workplace battles wisely when considering a disciplinary action, this involves as summarized (Suder, 2020):

I. **Use discernment:** There will be challenging issues and/or individuals in the workplace that an RT supervisor has to deal with. However, an RT supervisor should take some time to differentiate between the issues you truly need to pursue versus the issues you should overlook and move on from.
II. **Identify that "safe" person to which you can turn:** A first-time RT supervisor should find someone they have trust in, that they can vent and talk to determine what workplace issues are worth pursuing, and which ones to just let go of.
III. **Ask for guidance:** When dealing with workplace conflict, go to a workplace manager that you can trust, or someone in Human Resources who can advise you on the best way to handle a problem with proper workplace etiquette.
IV. **Agree to disagree:** Even when you strongly feel you are right, if someone disagree with you, it is rarely about right or wrong, but instead about a difference of opinion. Therefore, agree to disagree and move on.
V. **Take the high road:** Always use tact and grace, and take the high road to handle contentious issues with fellow coworkers. Don't speak negatively of other people in the

workplace, and don't share information that is no one else's business. Treat people the same way you would like to be treated because, it makes you look bad when you attempt to make someone else look bad.

VI. **Stand your ground:** There will be times went it is absolutely necessary to stand your ground and take the appropriate action. Whatever, course of action that is taken it is important that workplace etiquette is always followed.

VII. **Determine a plan of action:** Once a determination has been made to deal with a workplace issue, do not react or respond too fast. Take some time and figure out the best course of action, and if it is an emotionally charged issue, then take 24 to 48 hours to cool off and calm down before taking any type of action. Consider who is the best person to speak to on the matter, and decide how you will approach that person. Think through those questions and determine what outcome over the matter you would like to see.

VIII. **Don't let concerns fester:** Sometimes it is a good idea to avoid confrontation, but it is not always the way to handle a situation. It is often better to take care of a problem sooner than later, and if you decide not to confront the person involved with the issue, then you should discuss the matter with someone you can vent with, to prevent things from become heated with the person that is involved with the issue.

IX. **Mind your own business:** A first-time RT supervisor should be aware of the type of conversations they might have in the workplace because, you never know when it might be looked at as an attempt to get into someone else's personal business. There is no need to concern yourself with someone else business unless it negatively affects your work, or the workplace. RT supervisors should avoid conversations, that could lead toward to sharing and receiving personal details about the staff they supervise in the workplace.

X. **Attempt to keep your focus on work and productivity:** It takes a great deal of energy to deal with and resolve conflicts, and that can affect productivity in the workplace, and cause an RT supervisor to lose focus. As long as we are working with humans eventually there is always going to be some type of conflict in the workplace, and it is best to deal with the conflict sooner than later so you will not be consumed by the problem down the road. Seek guidance on conflict if necessary. However, it is important to keep focus on the bigger picture in the workplace, and use good judgement and etiquette to decide if it is necessary to speak up on an issue, or let the issue go because it might not be worth the time and energy to deal with it (Suder, 2020).

First-time RT supervisors are nervous when they initially accept a position, and they should meet with the hospital's Human Resources Employee Relations specialist as soon as possible after they accept the position to learn how to deal with conflict before an actual confrontation occurs. So they will know how to handle a disciplinary action if necessary, or avoid a disciplinary action that might not be necessary. This is also why it is important to meet with the hospital's compliance officer who is responsible for making sure the hospital's Code of Conduct is understood, that requires:

I. That disciplinary standards are well-publicized and readily available to all hospital personnel.
II. Disciplinary standards are enforced consistently across the entire organization.
III. Documented thoroughly each instance involving the enforcement of disciplinary standards.

IV. Require all employees, contractors, vendors are checked routinely against government sanctions lists, including the OIG's List of Excluded Individuals/Entities, and the General Services Administration's Excluded Parties Listing System.

V. It is important that first-time RT supervisors become familiar with the hospital disciplinary regulations, and it is the role of the Human Resources to administer discipline in accordance with the organization's “progressive” disciplinary action, or major adverse action, or other corrective action will be taken, as an example I submitted the Department of Veterans Affairs Employee/Management Relations VA Handbook 5021/15, Pg. I-A-3, Tables of Penalties for Title 5 and Title 38 for disciplinary actions (VA, 2013) (See Appendix O).

VI. **The Code of Conduct:** This is a stand-alone document that all employees must receive, read, and understand the standards (code) of conduct. Training should be provided specific to the code of conduct. Employees should attest in writing that they have received, read, and understand the standards of conduct on an annual basis. Employee compliance with the standards of conduct must be enforced fairly and consistently through appropriate discipline when necessary. Employees should understand that noncompliance will bring about discipline; this should be stated in the code of conduct.

VII. **Knowing when to pick a battle:** This is a talent that usually is acquired over time, and a first-time promoted RT supervisor must make an effort to develop this talent so their chances to be successful are increased.

4.13 UNION INVOLVEMENT

A first-time RT supervisor position is an extremely difficult position to manage that many have not been able to handle. This involves managing your RT staff, and people above

and below you in management, human resources, the entire hospital administration, supervisors and staff from other departments that interact with the RT department, vendors, family members, outside agencies, and the Union. A first-time RT might get lucky and get an immediate supervisor that is experience with managing people in a healthcare organization, or maybe not. In that case nobody is going to prepare you for what you will need to know or advise on the best way to handle issues from one extreme to another as they come up and how to interacting with the Union, and as a previous first-time RT supervisor who went through the "school of hard knocks" I am offering some real world information you should remember as follows:

I. Meet with the Union President to establish a positive relationship before there is any type of a Union grievance and let him know he or she can negotiate with you to deescalate issues when possible.

II. It is very important that all first-time promoted RT supervisors, as soon as possible should read and be familiar with the entire Union Collective Bargaining Agreement (SHRM, 2020).

III. A new supervisor must realize they cannot stop or interfere with an RT employee from going to the Union, and an employee does not have to tell you when they would like to go to the Union. Therefore, by telling an employee that it would be appreciated if they have a problem(s) to bring it to you as the RT supervisor first before bringing it to the Union, that could be misconstrued as a warning or threat with an employees' right to go to the Union without intimidation, and if later you have a problem with an employee the Union could make the suggestion of an allegation that an employee is being retaliated against for not complying with your come to me first suggestion, and you might get hit with a Union grievance for harassment.

IV. Never hold a grudge or take anything personally when as a first-time RT supervisor you get attacked by the Union that is part of the job.

V. It is also important to know that an inexperienced RT supervisor should be aware a Union President may encourage an employee to lie on an RT supervisor, because even if the Union fabricates an issue against an RT supervisor there are no consequences for that against the Union.

VI. On the other hand, if an employee comes to you first before going to the Union to resolve a problem, you should make every effort to resolve the problem if possible without the Union involvement. A first-time RT supervisor has to make sure they do not look like they only make their worth when they are writing someone up for a disciplinary action.

VII. As a first-time RT supervisor don't create snitches within the RT department to find out what is going on in the Union or other places. If an employee attempts to come to you in confidence with some privilege information that you should not know, "do not entertain it." Remember, employees that can't be trusted by their own coworkers, you can't trust them either.

VIII. Never take an I-don't-care attitude toward the Union, because the Union President has access to senior management in the C-suite, and the less your name is brought up the better for you even if you are within your legal rights with an RT employee.

IX. Be very careful with the Union because the Union can cause you to lose support with upper management if you get hit with too many grievances even if you are in the right. Upper management will look down on you for not exploring all your options to resolve problems in a win-win situation when possible without it resulting in a grievance.

X. A new RT supervisor should keep two copies of all Union grievances, one goes in the employee record and the other goes into a folder of all the complaints in chronological order. So, if you need to see a prior union grievance for a variety of reasons you can quickly assess it to investigate an issue without having to go through every personnel record to find a Union grievance that you are looking for.

XI. As a first-time RT supervisor there is something you should know and that is every time you get into a confrontation with the Union over an employee, your job is not the only job that could be jeopardize. By standing firm with the Union over a disciplinary action the Union representative will complain about you to your immediate supervisor and more than likely that will be the RT Medical Director, unless the RT department is under the nursing service then it will be a nursing supervisor, and then if the Union representative does not get the satisfaction he or she is looking for, the Union representative will then escalate the matter to the next level of respiratory therapy management and more than likely that will be the service chief that the respiratory therapy department is under, and if the Union representative does not prevail he or she will bring the complaint to senior management in the C-suite and start attacking everybody in the respiratory therapy line of authority, and if the Union is not successful at that point they may just accept the decision that has been made about the matter or take it out of the house.

The point I am trying to make is that even if you are legally in the right if enough complains constantly make it to the C-Suite it will eventually indicate you don't have the ability the manage issues without constantly putting out fires and seeing them evolve to a Union or other type of administrative grievance as result of your

inexperience, and that is part of the strategy the Union will use against you to make life as first-time RT as difficult as possible.

A first-time RT supervisor needs to know that their supervisors can also be considered part of the problem by the C-suite senior management for not advising you on how to handle contentious issues in a different manner when you are a first-time inexperience RT supervisor. Based on what is going on after enough complaints have made it to the C-suite the executives in the C-suite will start to question the RT management above the RT supervisor about what is going on in the RT department. A first-time RT supervisor needs to realize that people can get themselves out on a limb over you, and at this point you may have strong support or your support can become weaken. Once your supervisors see where they have some liability as a result of supporting you as a first-time RT supervisor while you are learning by trial and error on-the-job because they should have been advising you differently. They will either help you to become a better supervisor or it will strain your relationship with your immediate supervisors even though they thought they was doing the right thing by supporting you. Every RT Chief and RT Medical Director that have done the job for a long will tell you there were times when I wish I had handle things differently.

As a first-time RT supervisor this is the main reason why you need an immediate on-demand emergent administrative training program because you must learn to consider all the ramifications of your actions with regards to how they will affect other people in the RT management line of authority and the other people that might be involved because you really don’t who can trust. In view of the fact that your immediate RT supervisor might not explain to you or advise you as a first-time RT supervisor the

best way to deal with contentious issues because they just did not realize it was necessary to so.

First-time RT supervisors need to realize that there are factors that include but are not limited to that indicate how well their immediate supervisors will support them. The first factor an RT supervisor should understand and that is managing people is not for everybody and the RT Medical Director or nursing supervisor immediately over the RT department and the service chief that is usually a pulmonary or anesthesiology doctor have a lot to lose, and most of the time they don't usually ask for the job and the service chief over them will ask them or coaxed them to take to take the RT Medical Director position when they was not hired for that, and he or she really does not want the job and you can't expect that type of immediate supervisor to advise a first-time RT supervisor appropriately in order to develop into an effective RT supervisor.

On the other hand, the RT Medical Director may not have supervisor any type of clinical staff before, and might have never been taught, in this case the first-time RT supervisor and the RT Medical Director are both learning by trial-and-error on-the-job and have a little or no supervisory experience. Then there is the case where the RT Medical Director don't manage staff as well as they should base on what they have been taught and the amount of supervisory experience they might already have with people because personnel management is not for everybody including doctors.

Some RT Medical Directors over a first-time RT supervisor get nervous when they have to interact with senior management in the C-suite when it comes to supporting a first-time RT supervisor, and you never really know how much you might or might not get supported. There is just so much a first-time RT supervisor needs to

consider before they bring a disciplinary issue to their immediate supervisor attention, or make a recommendation for a disciplinary action. Therefore, a first-time RT supervisor must consider all the ramifications when considering a disciplinary action to the best of their ability.

XII. A first-time supervisor that has never been involved in a disciplinary action that could progress up to a termination process is not going to be prepared to take an employee through the contentious disciplinary process that is a responsibility of an RT supervisor with the Union. The worst part of the termination experience is on the RT supervisor because once it has been brought to your attention that one of your employee(s) has committed an offense so bad they can be considered for termination you must as the RT supervisor:

A. Inform the RT Medical Director or the appropriate nursing supervisor if the RT department is under the nursing service and the Service Chief that the RT department is under and make a recommendation for termination if you think a termination is warranted, or just report the facts and stay neutral about the matter because you will be told what to do.

B. Once your immediate supervise and the Service Chief agrees that a termination is necessary the RT supervisor should contact the Employee Relations Specialist that handles the RT department in Human Resources (HR).

C. Once HR has agreed with the RT department management to terminate the employee the RT supervisor has to investigate the misconduct, and at that point the RT supervisor must make arrangements to speak to the employee with Union representation to investigate the matter. Subsequently, if the Union thinks you are

wrong they will tell you and then the Union might start to attack you up the line of authority to senior management in the hospital's C-suite.

D. Once the RT supervisor has completed the investigation and wrote up a report the Service Chief has to sign off on it, or the immediate supervisor over the RT department if the Service Chief has given him or her that authority.

E. Then the RT supervisor has to take the documentation to HR for review, and HR depending on the circumstances HR may have the request for termination reviewed by the General Counsel office. It may not be necessary to consult with General counsel if the employee is on a temporary appointment that will expire soon.

F. After the HR review and the termination is approved, HR will signed off on the termination paperwork to serve the employee.

G. The next action is to make an appointment for Union representation in the Union office with the employee, and inform the employee that he or she has been terminated 14 days from the effective date of the termination paperwork.

The process is a very unpleasant experience, and based on how you handle the situation it could damage your relationship with the Union and the rest of the RT staff. There are many issues to consider with the termination process that I had to learn by trial and error, and it should be the very last resort to deal with a problem employee, unless an offense is so severe or a progressive pattern of misconduct warrants an immediate termination.

4.14 RT AND THE U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

New first-time RT supervisors should meet with the EEO officer as soon as possible to become familiar with the EEOC complaint process (EEOC, 2020), and become aware of Prohibited Employment Policies/Practices that states, "Under the laws enforced by EEOC, it is

illegal to discriminate against someone (applicant or employee) because of that person's race, color, religion, sex (including gender identity, sexual orientation, and pregnancy), national origin, age (40 or older), disability or genetic information. It is also illegal to retaliate against a person because he or she complained about discrimination, filed a charge of discrimination, or participated in an employment discrimination investigation or lawsuit." (EEOC, 2020).

4.15 RESPIRATORY THERAPY STAFF RECRUITMENT

RT staffing is a critical issue and recruitment is an ongoing process that never stops and unless a first-time RT supervisor takes over a brand new RT department as the case would be from a just built hospital staffing for the RT department will already be in play. The first major challenge to staffing an RT department that a first-time RT supervisor should be aware of is having to recruit staff to the RT department. First-time RT supervisors should establish a relationship with all the academic RT programs in their area to set up a clinical affiliation with them. Before you start having RT students rotate in your RT department for clinical rotations you should prepare your RT staff on how you expect them to interact with the RT students, because it is very easy to lose an RT clinical affiliation from something you did not give a thought about that an RT program Director might not like from a student compliant, and you should be aware of how delicate the clinical relationship with an RT program to prevent that situation in order to recruit RT students on clinical rotations before they graduate.

Beware of the RT programs politics in your area because some RT programs have geographical territorial agreements with each other. Whereas certain RT programs will not send their RT students for clinical rotation to hospitals in each other's area, and that will prevent you from being able to receive RT students for clinical rotations from certain RT programs in an area near you. However, you can get around that if you have a good relationship with the chairperson

of the RT program(s) that is not sending students into your area, and convince him or her to pull out of the territorial agreement to help you get RT staffing.

Even if you don't have a clinical affiliation with a certain RT program that is a little further away outside of your area, it is a good idea to ask the chairperson of that RT program could you come to the school and introduce yourself to the students, and pitch your RT department to them, so they will submit their resumes to you when they graduate. Depending on when you establish a clinical affiliation with an RT program it may not immediately solve a staffing shortage if you have to wait some time for the next graduating class of RT students to graduate.

In that case if you are critically short staffed you will work with your hospital recruitment specialist in Human Resources to approve an advertising budget to post the availability of your RT positions in the RT trade magazines, and depending on how bad you may need RT staff offer recruitment bonuses to attract Respiratory Therapists from anywhere in the country, then you can recruit through temporary RT travel contracts and from the local temporary RT staffing agencies to immediately deal with your Respiratory Therapist staffing shortage. It is also important to attend the local area job fairs to recruit Respiratory Therapists looking for work.

Next there is the issue of justifying the level of RT staff you may need to run your RT department. As a first-time RT supervisor when you first take over an RT department I recommend you conduct a time motion study as soon as possible. When justifying the RT staffing levels the RT supervisor has to conduct a time motion study of each area that RT services are provided for based on a 40 hour work week over the course of a year, or if you do not conduct a time motion study over a year it should be done during peak census and low census period of the year to ascertain the average workload in all assigned areas for RT services to

justify a part-time or full-time staff. This done by having the Respiratory Therapist write down every procedure they have completed on a form or spreadsheet, and then compare each procedure entered to a time standard from the AARC Uniform Reporting Manual (AARC11, 2020) to determine how much time it took to complete a day's work.

Once a time motion study has been calculated over the course of a 52 week year, then you have to subtract vacation time, break times, lunch times, educational and training times, allowable sick leave, and time off for any other expected reason, the remaining number of hours is what it will take to justify a full-time or part-time employee to provide RT services to an assigned area over a year, and the expected calculated time off hour is used to justify agency staff to cover for Respiratory Therapist time off.

4.16 RESPIRATORY THERAPIST STAFF INTERVIEWING

As a first-time promoted Respiratory Therapy supervisor eventually you will have to interview and hire RT staff for the first time, and the first thing you should be aware of is that you must be absolutely fair in the interviewing process to avoid having a complaint filed against you, that could eventually lead to a lawsuit.

RT programs routinely try to prepare their RT students for the interviewing process so they will have some idea as to what to expect. Long time RT interviewers usually evaluate Respiratory Therapists from their resumes, based on their appearance, the articulation of their strengths and weaknesses and the reasons they would like the position they are applying for. How well they can sell themselves, the impression they have made on social media, their benefit to the organization going forward, and the questions asked by an applicant at the end of the interview process, such as the potential for training and growth, RT protocol utilization, shift and assignment practices, and the orientation process (AARC3, 2020).

On the other hand, RT applicants can be evaluated in an interview based on a "Behavior Fit" without clinical questioning that will find out what you have learned in life, and how you will apply that knowledge to the job you are applying for. RT Student graduates only have a basic understanding of how to practice RT when they graduate anyway, and they still have to be taught clinical skills of the real world of RT later (AARCl, 2020). Behavioral fit interviewing revolves around asking questions that will allow an RT interviewer to assess a candidate based on their professional maturity, flexibility, life experiences, communication style, and conflict resolution skills (AARCI, 2020). Applicants that would be a poor behavior fit can kill department teamwork and morale, that is why it is important to select candidates that would be a good behavioral fit.

There are some real world issues that have to be considered that a first-time promoted RT supervisor is not going to be aware of, that I discovered over time. The manner in which the interviews will be conducted depends on how bad an RT manager might need staff in general, or when competing for staff in a high cost of living area, or how many applicants you might have at any given time to interview. There can be a time when you have only one applicant and you are so desperate for staff, that you have no other choice but to shorten the official interviewing process and hire on a first come, first served basis if their background checks, urinalysis and references are good.

There are several different options to have an effective interviewing process to select good quality people, and that can be done solo by the Chief of RT, or with a panel of personnel from the RT department, or a combination of RT staff members and staff from other services that the RT service interacts with. However, you decide to conduct interviews it must be done in the same manner, and fair to all applicants in a group that is competing for a position.

4.17 RT WORK SCHEDULING AND ASSIGNMENT WORKLOADS

Most Union master agreements, such as with the Department of Veterans Affairs require that the work schedules be posted two weeks in advance, or you can be subjected to a Union grievance, and more than likely a first-time RT supervisor may need to make changes in the RT department scheduling and assignments practices, that some of the RT staff in the department will not like, and a first-time RT supervisor has to make sure that the shift scheduling and workload assignments are administered in a fair and equal manner. Most Respiratory Therapist prefer to work 12-hour shifts plus one 8-hour shift to complete an 80 hour pay period every two weeks. However, on occasion an RT department will staff with 8 hour shifts.

One benefit of using 12 hour shifts is because it takes two full-time employees, and not three employees to cover one assignment area (e.g. ICU Front) over a 24 hour period, and it is possible with 12 hour shifts to give the RT staff three days off in-a-row, and grant Fridays off if an RT has to work on Saturday and Sunday, and grant Saturday and Sunday off when they have to work on a Friday. This means it may not be feasible to give everybody every weekend off, but when they do have to work the weekend at least they are given Friday off, and that makes working the weekends with 12 hour shifts as fair as possible. Next is an example of scheduling a two week pay period using 12 hour shifts to cover one area, such as the front of the ICU.

ICU FRONT	Sat	Sun	Mon	Tues	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri
DAY	12	12	12	off	off	off	8	off	off	off	12	12	12	off
Nights	off	off	off	12	12	12	off	12	12	12	off	off	off	8

As a first-time RT supervisor I inherited a situation whereas I had certain Respiratory Therapists that worked the same work assignment area every day, and one Respiratory Therapist got a prior RT supervisor to allow her to work only on the weekends, which allowed the one RT that complemented her on the night shift to have every weekend off, which was not fair to the other Respiratory Therapists that had to rotate on weekends. In addition I had one other Respiratory Therapist that was working on 8 hour shifts while all the other Respiratory Therapists were working 12 hours shifts, and the prior RT supervisor went along with that to keep the RT staff happy. There were several reasons why the scheduling practices agreed to by the previous RT supervisor were not a good idea, such as:

I. It was not fair for one Respiratory Therapist to always have an easy assignment while another Respiratory Therapist had a more demanding assignment every day.

II. RT staffing on the weekends is the most difficult, and when the Respiratory Therapist that wanted to only work weekends started to call in sick frequently, that created a big staffing problem on the weekends, and that practice was not fair to the other Respiratory Therapists that wanted every weekend off too and it was not feasible. By rotating the weekends with all the RT staff it greatly reduced the difficulty to staff on the weekends.

III. Respiratory Therapists have different levels of skills, and by rotating all assignment the strong and weak talents of the Respiratory Therapists will be spread evenly throughout the patient population. This will allow an RT supervisor to assess the Respiratory Therapist's talent in the department, and if there are any RT skill deficiencies when they rotate assignments, training can be provided to improve the Respiratory Therapist’s competency levels in the RT department.

IV. Once you allow a Respiratory Therapist to work the same assignment every day the chances are increased for a Respiratory Therapist with a drug addiction problem to steal narcotics. I know this from a personal experience when as a new first-time Chief of RT I started rotating work area assignments every day, and it took one RT with a drug problem out of his comfort zone, and that led him to taking a bigger risk to steal narcotics and that caused him to be caught and terminated.

V. It is never a good idea to allow one person to work only eight hour shifts while everybody else in the department worked 12 hour shifts because, every day when that Respiratory Therapist on an eight hour shifts gets off work, another 12 hour shift Respiratory Therapists has to pick up the workload of that Respiratory Therapist on eight hour shifts when he or she gets off duty.

VI. Even though I needed to make scheduling and assignment changes, when I attempted to do so I got slapped with a Union grievance because, I was required by Union agreement to go through the Union in order to make personnel changes that were contrary to past practices for a long time. That is one reason why it is very important for a first-time promoted RT supervisor to read the Union Master Agreement before they attempt to make changes that will affect Union personnel.

4.18 ANNUAL RESPIRATORY THERAPY STAFF APPRAISAL EVALUATIONS

In this section I will discuss the evaluation process in general by using the Office of Personnel Management's (OPM) regulation for measuring employee performance as an example (OPM, 2017). First-time RT supervisors that have to do a performance evaluation for the first time should read their healthcare organization's regulation on performance evaluation appraisals

before they attempt to administer one for the first time to prevent a grievance and/or bad feelings in the department.

As a new RT supervisor eventually you are going to have to do your first RT department annual performance appraisal evaluations, and this will be an awkward experience until you have done it a few times and gain some experience at doing it. In all cases a first-time promoted supervisor(s) should ask themselves; "Do I want to treat the employees in the evaluation process the same way I was treated?" There is a chance that when you was evaluated by one of your prior RT supervisors you may have felt you were not treated fairly, and if that is the case you should learn from it so you will not make the same mistake with your RT staff.

Another very important point that a first-time RT supervisors should realize is that, they should do some direct patient care on a consistent basis because, eventually as the RT supervisor you are going to have to cover for your RT staff periodically and do direct RT patient care, and if you only do administrative work over time you will lose your RT clinical skills, and the RT staff will notice it because you will start to make mistakes and ask for help over RT issues that was second nature to you when you was practicing RT every day. Then it is going to be difficult to evaluate a respiratory therapist for the RT work they have done when you as the RT supervisor with the same license cannot function up to an expected level of competency that you are rating them for. This is why the Chief of Anesthesiology or Surgery still do patient cases so in case they may need to cover for one of their doctors they still can do so.

Administering a performance evaluation can be a contentious event and that is not the time to criticize an employee, but that is the time to express some appreciation for the work they have done, and celebrate an employee's accomplishments over the evaluation period, and then make some suggestion(s) for improvement if needed (AARC7, 2020). From the American

Association for Respiratory Care (AARC7, 2020) performance evaluations should be centered around behaviors rather than attitudes because the latter simply can't be measured.

Traits that needs to be considered when evaluating a Respiratory Therapist can include, but not limited to the ability to work with a team, function with less than normal supervision, provide quality work, maintain good attendance, display a positive behavior, demonstrate good communication and interpersonal skills, ensure safety, and have a trustworthy relationship with your coworkers, in the workplace. Serve with compassion not with just patients and families, but with Respiratory Therapists and other hospital staff members. Being honest enough to admit and learn from mistakes (AARC7, 2020).

4.19 HOW RERSPIRATORY THERAPY SUPERVISORS ARE EVALUATED

First-line clinical supervisors are the least experienced tier of supervisors in a healthcare organization, and from the enter for Creative Leadership the most critical frontline leadership skills are (CCL, 2021)

I. **Self-awareness:** Managers who are mindful of their strengths, weaknesses, and training needs are better prepared to make operational decisions and interact effectively with others who have different personalities.
II. **Learning agility:** Learning from mistakes and seeking out different points of view to apply to new challenges, and taking what you have learned to adapt to the environment allows managers to quickly identify, examine, and address new problems.
III. **Communication skills:** RT supervisors are frontline supervisors that must consistently communicate with people in all levels of employment and involvement with a healthcare organization this includes, but not limited to superiors, pers, team members, family members, vendors, and others.

IV. **Political savvy:** It is essential that first-time RT supervisors start learning their environment as soon as possible, and learn to relate well with people to develop strong working relationships with other managers and superiors to achieve goals is a key competency for frontline supervisors.

V. **Motivating others:** First-time RT supervisor supervise Respiratory Therapists to do work that they are also licensed to do also, and a successful RT supervisor had to be ready to lead by example and do extra work at any time to inspire commitment from the RT staff. The ability to motivate other is an essential skill to be a successful frontline supervisor.

VI. **Influencing outcomes:** Effective managers are able to influence staff to function at their fullest potential with less than normal supervision to achieve positive outcomes based on the circumstances.

First-time RT supervisors should have knowledge of how they going to be rated by the healthcare organization they work for. Most competencies and performance appraisals for clinical frontline supervisors from healthcare organization to another are comparatively similar and may vary based on a unique need in a healthcare organization. There are National Frontline Supervisor Competencies standard written by the University of Minnesota (Sedlezky, 2013), that can be used to tailor frontline supervisor performance competencies and evaluation appraisals based on the specific needs of a healthcare organization. The University of Minnesota National Frontline Supervisor Competencies are nationally recognized, and as quoted, "the NYS Talent Development Consortium has adopted and adapted the University of Minnesota's "Frontline Supervisor Core Competency Set" with permission" (RCWT, 2017). The National Frontline

Supervisor Competencies from the University of Minnesota consist of 120 competencies in 11 sections that are quoted as follows (Sedlezky, 2013),

I. "Direct support; eight competencies.

II. Health, wellness, and safety; 16 competencies.

III. Participant support plan development, monitoring and assessment; nine competencies.

IV. Facilitating community inclusion across the lifespan; 16 competencies

V. Promoting professional relations and teamwork; 11 competencies

VI. Staff recruitment, selection, and hiring; nine competencies.

VII. Staff supervision, training, and development; 13 competencies.

VIII. Service management and quality assurance; 15 competencies.

IX. Advocacy and public relations; 10 competencies.

X. Leadership, professionalism and self-development; eight competencies.

XI. Cultural awareness and responsiveness; five competencies."

CHAPTER V

CONCLUSION

5.1 DISCUSSION OF RESULTS

It is impossible to teach a first-time RT supervisor with little or no prior supervisory experience everything they may need to know in this on-demand emergent administrative training program, and there are other leadership strategies to be considered to achieve the objectives in this dissertation project. However, this program has been designed to teach first-time RT supervisors a thought process and provide training to deal with RT supervisor's duties as they gain supervisory experience, that will help them make the best possible decisions on RT issues as they become proficient with the administrative skills required of RT supervisors and transition into RT management as smoothly as possible to run an RT department.

The administrative duties required of a first-time RT supervisor covered in this dissertation project are not taught as part of a clinical RT college program, and I have never seen an on-demand emergent administrative training program like the one I have developed, and the there was no program like this in the American Association for Respiratory Care data base. The evaluation of the effectiveness of this program has to be determined in the future. However, if you look at the balance approach I used with the interaction that has to be made with the different people in the process of managing an RT department there is a great deal of information to be assume that will result as of this emergent administrative training program. The AARC has seen merit in this administrative training program and has expressed an interest in making this dissertation project part of the AARC educational portfolio. Over time first-time RT supervisors with the guidance of this emergent administrative training program will result in better

collaboration and relationships between the disciplines within the healthcare organization. The RT supervisor will be much more relaxed and confident in the way he or she will approach problems, and that will reduce complaints and grievances. Consequently, there will be an improvement in patient satisfaction and the RT department morale will improve because this emergent administrative training program encourages buy-in from all the RT staff.

5.2 LIMITATIONS

There are limitations to this on-demand Emergent Administrative Training program because there are situations where it is absolutely necessary for a healthcare organization to hire an experienced RT supervisor. For instance, I would not implement this program in a rural hospital where Respiratory Therapists have increased responsibilities compared to urban and teaching hospitals. In rural hospitals Respiratory Therapists intubate and function with far less supervision than what they would receive in urban and/or in teaching hospitals, and depending on how inexperienced a Respiratory Therapist is when he or she might apply for a RT supervisor position in a rural hospital, it would not be ideal to teach someone what they don't know as a Respiratory Therapist and then teach them what they need to know to be an RT supervisor.

Based on the working environment of certain hospitals it would not be wise to hire a Chief of RT without prior supervisory experience. Many hospitals have a very high turnover rate for RT department managers, and that could be because of the way the RT Staff, the union, upper management, other clinical and administrative departments interact with an RT supervisor, and unless there was a supportive environment I would not implement this training program.

This administrative training program does not guarantee a first-time RT supervisor will be successful because there are many other factors that play into the ability to manage an RT department successfully, that stems from being born with the innate ability to lead a RT

department and/or the ability to be taught how to lead a RT department (Boerman, 2017), and after you have taken that into consideration leadership skills are innate or you can be taught leadership you can still fail, and failure can ultimately make you a better RT leader (Llopis, 2012) when you learn from it, or better yet learn from others mistakes to avoid them. I say that because over the course of 24 years in VA hospitals I have seen hospital directors get removed, doctors terminated and other people in high level position with years of experience and management education still fail in a position from incompetence.

5.3 FUTURE RESEARCH

There will be future research on this dissertation topic because currently the administrative duties required of an RT supervisor are learned on-the-job as an inexperience RT supervisor gains experience, and are not taught in detail as part of an academic clinical Respiratory Therapy college program. Respiratory Therapy as a profession is growing very fast. Back in 1995 there were around 20 baccalaureate programs and no Master's degree programs. Now as of 2019 there are 70 Bachelor RT programs and five Master's degree programs. The Immediate Emergent Administrative Training program I have created is going to be the next expansion of RT management education in RT education programs.

There will be research done to build on this dissertation project using qualitative research methods that include case studies, empirical research, observational method, one-on-one interviews, focus groups, and text analysis (QuestionPro, 2020). It is only a matter of time before there is a Respiratory Therapy program on the Doctorate level that will give Respiratory Therapists the same autonomy that is enjoyed by Nurses and Physical Therapists.

5.4 CONCLUSION

In summary, there is definitely a need for an immediate on-demand emergent administrative training program for first-time respiratory therapy supervisors, that are required to supervise respiratory therapists and ensure they do not harm, or cause the death of a patient in a hospital. The administrative duties of an RT supervisor are not taught as part of a clinical RT education program and are learned by trial and error on-the-job. The lack of education in this area has cause a training gap for students leaving an RT educational program that does not prepare them to be supervisors in their own RT profession, and this dissertation project is a first attempt to provide training to exclusively address that issue with first-time RT supervisors with little or no prior supervisory experience.

This program can also provide Students and Respiratory Therapists interested in RT management with a real-world perspective on what to expect as a first-time RT supervisor so they can transition into RT management as smoothly as possible. Another important issue that first-time RT supervisor should consider and that is the fact they are not entitled to be RT supervisor and you don't know who you can trust in an RT supervisor's position. It is very rare does an RT supervisor last 20 to 30 years in the same position, it does happen but it is rare, and beware that it very easy to lose an RT supervisor position. Therefore, from the very beginning of accepting an RT supervisor position continue your education so if you have to leave an RT supervisor position you will have strengthen your resume to find another RT supervisors position or a job somewhere else.

Furthermore, this On-demand emergent administrative training program can also be used as a model for the training or other first-time allied clinical frontline supervisors with little or no prior supervisory experience.

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Appendix A
Respiratory Care Programs and Satellites by Degree for 2013 through 2019

Table 2 – RC Programs and Satellites by Degree for 2013 through 2019							
	as of 12/31/13 (N=441)	as of 12/31/14 (N=438)	as of 12/31/15 (N=427)	as of 12/31/16 (N=428)	as of 12/31/17 (N=443)	as of 12/31/18 (N=430)	as of 12/31/19 (N=420)
Associate of Science (AS)	215	196	172	153	136	122	113
Associate of Applied Science (AAS)	161	174	186	198	227	228	226
Associate of Specialized Technology (AST)	3	2	2	3	4	4	4
Associate of Occupational Studies (AOS)	2	2	2	3	3	2	2
Bachelor of Science (BS)	57	60	60	64	65	66	67
Bachelor of Applied Science (BAS)	0	1	1	1	2	2	3
Master of Science (MS)	3	3	4	6	6	6	5

Appendix B
National Board for Respiratory Care 2019 Credentials Awarded

NBRC
The National Board for Respiratory Care

2019 Examinations in Review
January through December

Examinations Administered and Credentials Awarded

Our testing agency, PSI, administered 28,897 NBRC examinations in 2019, and we awarded 14,038 new credentials during the year.

As of December 31, 2019, the total number of credentials we have awarded to date, climbed to 466,098.

	2019 Examinations Administered	Credential	2019 Credentials Awarded	Total Credentials to Date
Therapist Multiple-Choice	15,078	CRT	6,136	256,605
Clinical Simulation	11,040	RRT	6,129	169,240
Pulmonary Function Technology	525	CPFT	251	14,089
		RPFT	137	4,991
Neonatal/Pediatric Specialist	1,130	RRT-NPS	663	16,075
Sleep Disorders Specialist	155	CRT-SDS & RRT-SDS	121	820
Adult Critical Care Specialist	969	RRT-ACCS	601	4,278

Passing percentages for 2017 - 2019 can be found on the next page.

Appendix C
Certified and Registered Respiratory Therapist Qualification Standards

APPENDIX G10. CERTIFIED RESPIRATORY THERAPIST QUALIFICATION STANDARD
Veterans Health Administration

1. COVERAGE. The following are the overall requirements for appointment of a CRT (certified respiratory therapist) in VHA who performs or supervises technical work concerned with administering respiratory care and life support to patients with cardiopulmonary deficiencies and abnormalities.

NOTE: *Chapters 73 and 74, title 38, United States Code refers to "certified or registered respiratory therapists." Since the National Board for Respiratory Care, the certifying body for respiratory therapists, distinguishes between "certified respiratory therapist" and "registered respiratory therapists," we are adopting these titles for agency use.*

2. SECTION A. BASIC REQUIREMENTS

a. **Citizenship.** Citizen of the United States. (Noncitizens may be appointed when it is not possible to recruit qualified citizens in accordance with paragraph 3g, section A of chapter 3, this part.)

b. **Certified Respiratory Therapist.** Has been issued a certificate as a CRT by the NBRC (National Board for Respiratory Care) or a certificate from another body which the NBRC recognizes as its credentialing equivalent. This included certification based on either:

(1) Having successfully completed a respiratory therapy technician (1 year) or respiratory therapy program accredited by the Joint Committee for Respiratory Therapy Education and having passed the entry level examination administered by the NBRC since 1983, *or*

(2) Having a certificate as a respiratory or inhalation therapy technician based on passing an entrance examination administered by the (1) National Board for Respiratory Therapy from 1975 through 1982; (2) Technician Certification Board of the American Association for Respiratory Therapy from 1972 through 1974; or (3) Technician Certification Board of the American Association for Inhalation Therapy from 1969 through 1971.

c. **Physical Standards.** See VA Directive and Handbook 5019.

d. **English Language Proficiency.** CRTs appointed to direct patient-care positions must be proficient in spoken and written English as required by 38 U.S.C. 7402(d), and 7407(d).

3. SECTION B. PART-TIME CREDIT. Part-time experience is credited according to the relationship it bears to the full-time workweek (e.g. a CRT who worked 20 hours a week, i.e., half-time, would receive one full-time workweek of credit for each 2 weeks of service).

4. SECTION C. GRADE REQUIREMENTS. In addition to meeting the basic requirements stated above, the following qualifications criteria must be met in determining appropriate grade assignments.

a. **GS-5.** None beyond the basic requirements.

b. **GS-6.** Successful completion of *one* of the following:

(1) A minimum 2-year accredited educational program of study in respiratory therapy.

(2) At least 1 year of experience related to respiratory therapy at the GS-5 level or equivalent. Experience at this level is work which included duties such as: administering oxygen and aerosols containing prescribed medications to patients involving the use of a variety of standard respiratory equipment; drawing and analyzing blood samples from patients; collecting sputum specimens using aerosol administration and tracheal suctioning; performing chest physical therapy using techniques such as clapping, vibrating, and postural drainage to facilitate the removal of secretions; calibrating equipment such as oxygen regulators and blood gas analyzers; and setting up and monitoring the operation of compressors, nebulizers, non-breathing masks, and co-oximeters. This experience must have provided the candidates with a wide knowledge of commonly used respiratory equipment, procedures and techniques, including an understanding of the basic medical sciences such as anatomy, physiology, chemistry, and physics and how they relate to the respiratory and cardiovascular systems of the human body; knowledge of the various respiratory diseases such as bronchitis, asthma, and emphysema, including the appropriate methods of treatment; and knowledge of commonly used respiratory drugs such as bronchodilators.

c. **GS-7.** Candidates must have successfully completed at least *one* of the following:

(1) A 4-year or more accredited program of study leading to a bachelor's or higher degree in respiratory therapy.

(2) In addition to meeting the requirements for the GS-6 level, an additional year of experience related to respiratory therapy at the GS-6 level or equivalent. Experience at this level is work which includes duties such as; setting up and monitoring complex respiratory equipment such as volume and pressure ventilators; performing airway care and maintenance on intensive care patients; performing specific diagnostic studies to determine oxygen consumption/carbon dioxide production, measure respiratory compliance, tidal volume and inspiratory force; drawing and interpreting results of blood gas analysis; providing oxygen and life support to patients during emergency resuscitations; assisting physicians in placing artificial airways into patient's trachea; and calibrating complex respiratory equipment such as pressure and volume ventilators, oximeters, and mass spectrometers. This experience must have provided the candidate with knowledge of the full range of equipment, procedures, and techniques used in respiratory therapy including the operating characteristics, capabilities, and limitations of the complex equipment (e.g. volume ventilators) used in intensive respiratory care and emergency situations. The experience must have also provided the candidate with knowledge of anatomy and physiology of the respiratory system including in-depth understanding of how the structure and function of the lungs and bronchi relate to gas exchange and ventilation; and a knowledge of caring for a wide variety of acute and chronic respiratory disorders.

5. SECTION D. ACCREDITED SCHOOLS. A listing of accredited educational programs in respiratory therapy may be secured from the Department of Allied Health Education and Accreditation, American Medical Association, 515 North State Street, Chicago, Illinois 60610.

6. SECTION E. DEVIATIONS. In cases where the application of the grade requirements will result in an inappropriate grade assignment, the appointing official may authorize a deviation from these requirements. Deviations to the GS-7 grade level ceiling should be requested for GS-8 and above inhalation therapy technicians who are or become certified respiratory therapists. Deviations from this ceiling may also be approved where necessary to avoid an inappropriate grade assignment, e.g., assignment of supervisory responsibilities warranting higher than the GS-7 grade to a CRT at a facility where a registered therapist is not available.

Authority: 38 U.S.C. 7304; 7402.

APPENDIX G11. REGISTERED RESPIRATORY THERAPIST QUALIFICATION STANDARD
Veterans Health Administration

1. COVERAGE. Following are the overall requirements for appointment of an RRT (registered respiratory therapist) in VHA who performs or supervises work concerned with administering respiratory care and life support to patients with cardiopulmonary deficiencies and abnormalities.

2. SECTION A. BASIC REQUIREMENTS

a. **Citizenship.** Citizen of the United States. (Noncitizens may be appointed when it is not possible to recruit qualified citizens in accordance with chapter 3, section A, paragraph 3g, this part.)

b. **Registered Respiratory Therapist.** Has a certificate as an RRT from the NBRC (National Board for Respiratory Care) and a registry number, or a certificate from another body which the NBRC recognizes as its credentialing equivalent. This includes registration based on either:

(1) Having fulfilled the requirements and passed the registry examination administered by the NBRC since 1983, or

(2) Having fulfilled the requirements and passed the registry examination for a registered inhalation or respiratory therapist administered by the (1) National Board for Respiratory Therapy from July 1974 through 1982 or (2) American Registry of Inhalation Therapists from 1961 through June 1974.

c. **Physical Standards.** See VA Directive and Handbook 5019.

d. **English Language Proficiency.** RRTs appointed to direct patient-care positions must be proficient in spoken and written English as required by 38 U.S.C. 7402(d), and 7407(d).

3. SECTION B. PART-TIME REQUIREMENTS. Part-time experience is credited according to the relationship it bears to the full-time workweek (e.g., an RRT who worked 20 hours a week, i.e., half-time, would receive one full-time workweek of credit for each 2 weeks of service).

4. SECTION C. GRADE REQUIREMENTS. In addition to meeting the basic requirements stated above, the following qualifications criteria must be met in determining the appropriate grade assignment of candidates.

a. **GS-7.** None beyond the basic requirements.

b. **GS-8.** Candidates must have *all* of the following:

(1) At least 1 year of successful experience related to respiratory therapy at the GS-7 level or equivalent. Qualifying experience at this level is work which includes duties such as: administering assisted and controlled ventilation to patients with tracheotomies and other complex medical problems

requiring frequent adjustments in ventilator parameters; administering and monitoring advanced ventilator techniques such as positive end expiratory pressure and continuous positive airway pressure; developing plans for weaning patients from ventilators; assessing the respiratory status of patients using data acquired through physical observation and clinical analysis of blood gas data, chest x-rays, and electrocardiogram to determine the effectiveness of therapy being administered and to make recommendations to physicians regarding changes in treatment; performing the most difficult respiratory therapy procedures to maintain ventilation, including endotracheal intubation, tracheal lavage, and tracheotomy care; and providing in-service training to others in various specialized areas of respiratory care.

(2) Demonstrated knowledge and ability needed to perform complex respiratory procedures with minimal supervision. Is able to participate with physicians and nurses and other staff in planning respiratory treatment, with great reliance on the individual's knowledge of the equipment.

(3) Demonstrated knowledge and ability to provide emergency or critical respiratory care; service as a shift leader or supervisor or sole responsible respiratory therapist on a shift; and to plan and conduct training sessions with respiratory therapy students, hospital staff, patients, and family members.

NOTE: *The use of the GS-9 and above grade levels is restricted to individuals performing one of the assignments indicated below for the grade.*

c. **GS-9.** In addition to meeting the requirements for GS-8, candidates must have had at least 1 additional year of successful and progressively responsible experience related to respiratory therapy at the GS-8 level or equivalent. This experience must have included demonstrated accomplishments in upgrading services to patients. The candidate must have demonstrated expert knowledge of respiratory therapy methods, equipment, and procedures and the ability to assume responsibility to plan, organize, direct, coordinate, and evaluate programs involving respiratory care. Serves as:

(1) **Chief of a Section (or Unit) Providing Respiratory and Related Care.** Supervises at least three employees (full-time equivalent) whose work involves providing respiratory and related care. Typically, duties and responsibilities will include:

(a) Assigns duties and responsibilities to staff relative to respiratory care of patients to include adequate work coverage at all times. Selective consideration is given to relative difficulties of assignments and capabilities of subordinates.

(b) Interviews candidates for subordinate positions in the section or unit. Makes recommendations for appointment, advancement, and, when appropriate, disciplinary action. Evaluates performance of the staff and identifies continuing education and training needs.

(c) Participates in in-service respiratory teaching and training, maintaining a close relationship with other disciplines and students who may rotate through the health care facility.

(d) Delivers respiratory care as needed in the more complex respiratory care procedures and to poor risk patients such as those in the older age group. Participates in the audit of respiratory care, recommending changes where indicated.

(2) **Assistant Chief.** Serves as a full assistant to a chief of an organizational element involved in providing respiratory and related care as described below for the GS-10 grade. Occupies a position in the direct supervisory line and shares in, and assists the chief with respect to, all phases of the organizational element's work.

d. **GS-10.** In addition to meeting the requirement for GS-9, candidates must have had at least 1 additional year of successful and progressively responsible experience in which the candidate demonstrated the ability to assume supervisory duties and function in an assignment at the GS-10 level. Serves as:

(1) **Chief of an Organizational Element (Typically a Section).** Has full responsibility for supervising at least seven employees (full-time equivalent) whose work involves providing respiratory and related care. Typically, duties and responsibilities will include:

(a) Plans work schedules and the sequence of operations, and recommends and implements changes in organization or work assignments to improve work, services, job satisfaction, etc. Also, recommends and justifies to higher authority changes with significant budgetary impact. In addition, develops and reports to higher level supervisors changes in budget requirements based on anticipated workload and productivity capability of the section.

(b) Assigns and explains work requirements relative to respiratory care for new or changed, as well as existing, programs. Resolves technical work problems, including those not covered by precedents or established policies.

(c) Develops and updates guidelines and policies for nonroutine or complex assignments.

(d) Keeps employees and higher level supervisors informed of matters that affect them. Has authority to prepare and follow up on actions for most supervisory personnel functions.

(e) Prepares formal requests for filling vacancies for additional personnel to meet work requirements.

(f) Selects or participates with significant influence in selection of employees from eligible candidates.

(g) Prepares requests and recommendations for promotions, reassignments and other changes, and incentive and employee recognition awards and special advancements.

(h) Formulates training and education plans for subordinates and arranges for appropriate training courses.

(i) Participates in both the planning and delivery of comprehensive in-service respiratory and related care teaching and training programs for subordinates and other staff in different disciplines. Plans instruction and participates as an instructor for the facility respiratory care educational program.

(j) Plans and participates in the audit of respiratory care, recommending changes where indicated.

(2) **Assistant Chief.** Serves as a full assistant to a chief or an organizational element involved in providing respiratory and related care as described below for the GS-11 grade. Occupies a position in the direct supervisory line and shares in, and assists the chief with respect to, all phases of the organization element's work.

e. **GS-11.** In addition to meeting the requirements for GS-10, candidates must have demonstrated the knowledge and ability to successfully assume supervisory duties and function in an assignment at the GS-11 level. Must have the ability to assume a high level of supervision of a large section and, as necessary, provide supervision to subordinate supervisors. Serves as a chief of such an organizational element and has a high level of supervisory responsibility for at least 15 employees (full-time equivalent) whose work involves providing respiratory and related care. Typically, duties and responsibilities will include:

(1) In addition to planning work schedules and operations, makes changes in the organization of work within allowable costs and established policies. Has the authority to develop plans and schedules for guidance of subordinate supervisors and other subordinates for the accomplishment of work to meet program goals, objectives, and broad priorities established by higher levels of management. This includes carrying out such responsibilities as:

(a) Analyzing work requirements and determining staff and resources needed to accomplish work.

(b) Reviewing and analyzing records and reports of work production, costs, and equipment and staff resources used to evaluate progress and control or reduce costs. Reports progress and resolution of problems in achieving goals and objectives to higher levels of management.

(2) Assigns and explains work requirements relative to respiratory care for new requirements or changes, as well as existing progress. Resolves technical work problems not covered by precedents or established policies for nonroutine or complex procedures. Studies continuing problems on the quality and quantity of work and operating effectiveness and takes or recommends needed actions.

(3) Develops and updates guidelines and policies for nonroutine or complex assignments.

(4) In addition to the authority to initiate formal and follow-up actions for personnel functions, has authority to establish internal guidelines and approve, modify, or reject personnel actions of subordinate supervisors or employees. Typically the individual:

(a) Selects or contributes significantly to the selection of key employees (e.g. subordinate supervisors).

(b) Hears individuals or group grievances and employee complaints.

(c) Recommends disciplinary actions involving key or other employees.

(d) Approves, modifies, or rejects career development or training plans or requests, employee utilization requests, and similar matters.

(e) Approves, modifies, or rejects formal requests from subordinates for promotion, reassignment, status changes, awards, special advancements, selection, and the like.

(f) Prepares formal evaluations of the performance of key employees or other subordinates and reviews evaluations prepared by subordinates.

(g) Where applicable, deals with union stewards and others on personnel matters.

(5) Has substantial responsibility for planning and implementing educational programs for in-service and other personnel and respiratory therapy students who rotate through the health care facility.

(6) Is responsible for auditing respiratory care and initiating or recommending changes where indicated.

(7) May assist in or participate in approved research activities involving respiratory care.

5. SECTION D. DEVIATIONS. In cases where the application of the grade requirements will result in an inappropriate grade assignment, the appointing official may authorize a deviation from these requirements.

Authority: 38 U.S.C. 7304; 7402

Appendix D
MUSC Quality Improvement / Program Evaluation Self-Certification Tool

MUSC QI / Program Evaluation Self-Certification Tool

Response was added on 10/30/2020 5:00pm.

MUSC QI / Program Evaluation Self-Certification Tool	
Today's date	10-30-2020

This tool is to be used to assist in determining whether a project may be deemed quality improvement (QI) / program evaluation and therefore not require IRB review or approval.

If you do not understand a question please refer to the [IRB website] for further information.

It is important that you answer each question objectively and truthfully. Each question must be answered as either YES or NO.

If, based on your responses the project is QI, a self-determination letter will be emailed to the address provided. This document can be given to individuals requesting written confirmation that IRB review of the project is not required (e.g. individuals providing data for the project, funding sources, journal editors, etc.), so the information here should include sufficient detail such that the certification can be matched to the project.

Note that this tool is designed to differentiate basic QI projects from research. It is possible that your project may be QI even if the tool identifies it as possible research. If the tool provides a determination that is different from what you anticipated, please contact the IRB at 792-4148 to discuss your project in greater detail.

Note that the determinations made by this tool are subject to audit by University Compliance Office.

**This guidance tool has been adapted from the University of Wisconsin-Madison's "IRB QI/Program Evaluation Self-Certification Tool"

Name of Project Leader/Investigator	Irving T Spivey
Email of Project Leader/Investigator	spiveyi@musc.edu (Note: must be an MUSC email address)
Project Title	Immediate emergent training for first-time promoted respiratory therapy supervisors without prior supervisory experience.

Describe the intent/purpose of your project. Describe the steps that will be taken to complete the project. (Restating the title is not acceptable).	First-time promoted Respiratory Therapy supervisor without prior experience have a training gap, and the purpose of this project is to provide an immediate training program exclusively for first-time RT supervisors without prior experience when they are initially hired to the position of a RT supervisors. I survey several past and Present RT manager peers, and have contact the America Association of Respiratory Care for research guidance on this project.
Brief Description of Project Goals	To provide an immediate emergent training program first-time promoted Respiratory Therapy supervisors with little, or no prior experience as Respiratory Therapy supervisor.
College/affiliation through which the project will be conducted:	◯ College of Dental Medicine ◯ College of Graduate Studies ⊗ College of Health Professions ◯ College of Medicine ◯ College of Nursing ◯ College of Pharmacy ◯ Other
Q1. Will the project involve testing an experimental drug, device (including medical software or assays), or biologic? [More info]	◯ Yes ⊗ No
Q2. Has the project received funding (e.g. federal, industry) to be conducted as a **HUMAN SUBJECTS RESEARCH STUDY**? [More info]	◯ Yes ⊗ No
Q3. Is this a multi-site project (e.g. there is a coordinating or lead center, more than one site participating, and/or a study-wide protocol)? [More info]	◯ Yes ⊗ No
Q4. Is this a systematic investigation designed with the intent to contribute to generalizable knowledge (e.g. testing a hypothesis; randomization of subjects; comparison of case vs. control; observational research; comparative effectiveness research; or comparable criteria in alternative research paradigms)? [More info]	◯ Yes ⊗ No
Q5. Will the results of the project be published, presented or disseminated outside of the institution conducting it? [More info]	⊗ Yes ◯ No
Q6. Is the project intended to improve or evaluate the practice or process within a particular institution or a specific program? [More info]	⊗ Yes ◯ No

This project appears to constitute QI and/or Program Evaluation and does not fit the federal definition of research. IRB review is not required.

If you plan to collect data, please refer to [https://horseshoe.musc.edu/everyone/information-solutions/information-security/policies], for proper data security.

Click "Submit" to have your Self-certification QI Determination Letter sent to the email address indicated.

Appendix E
Letter Indicating that this Quality Improvement Project is not subject to IRB review

MUSC
Medical University of South Carolina

Quality Improvement/Program Evaluation

Self-Certification Tool

Sponsored by the MUSC Institutional Review Board

Date: 10/30/2020

Project Title: Immediate emergent training for first-time promoted respiratory therapy supervisors without prior supervisory experience.

To: Irving T Spivey

Based on your responses to the IRB QI/Program Evaluation Self-Certification Tool, in which:

1. The project will not involve testing an experimental drug or device.
2. The project has not received federal funding to be conducted as human subjects research.
3. The project is not a multi-site project.
4. The primary intent of the project is not to conduct a systematic investigation designed to contribute to generalizable knowledge.
5. The results of the project will be published, presented or disseminated outside MUSC.
6. The project is intended to improve or evaluate the practice or process within a clinic or program at MUSC.

This project is determined to be quality improvement and is therefore not subject to IRB review or approval. If the project changes in any way, please repeat the use of this tool to determine if the project continues to be quality improvement.

If you indicated intent to publish your quality improvement endeavor, it is strongly suggested to use the SQUIRE guidelines when writing up this project for publication.

Please retain a copy of this Self-Certification for your records. The determinations from this tool are subject to audit by the University Compliance Office.

If you have any questions, please contact: The MUSC IRB 843.792.4148.

Appendix F
Contact Email example to Guide Interviews contacts

From: Irving Spivey <irvingspivey@hotmail.com>
Sent: Sunday, December 13, 2020 1:32 AM
To: Daniel, Brian <danielb@smccd.edu>
Subject: [EXTERNAL]Irving T Spivey Dissertation Project

To: Brian Daniels, RRT, Director of Clinical Education
Skyline College, Respiratory Therapy Program.

From: Irving T Spivey, MJ, BSRT
Doctoral Candidate, MUSC

Hello Brian,

I am in the process of completing my dissertation for a Doctor of Health Administration Program and the topic of my dissertation is,

IMMEDIATE EMERGENT ADMINISTRATIVE TRAINING PROGRAM
FOR FIRST-TIME RESPIRATORY THERAPY SUPERVISORS
WITH LITTLE OR PRIOR SUPERVISORY EXPERIENCE

The program curriculum consists of 21 sections that follows below:

1. Mistakes New Managers Make, 2. Creative Thinking, 3. Deductive and Inductive Reasoning, 4. Organizational Culture, 5. Meet with the Hospital Compliance Officer, 6. Hospital Compliance program, 7. Making a Risk Assessment, 8. Respiratory Therapy Disaster Preparation, 9. The Joint Commission, 10. Information System for Respiratory Therapy, 11. Respiratory Therapy Acquisition Material Management, 12. Respiratory Therapy with Telehealth, 13. Conflict Resolution, 14. Disciplinary Actions, 15. Union Involvement, 16. U.S. Equal Employment Opportunity Commission, 17. Respiratory Therapy (Staffing) Recruitment, 18. Respiratory Therapist Staff Interviewing, 19. Respiratory Therapy Work Scheduling and Assignment Workloads, 20. Annual Respiratory Therapy Performance Appraisal Evaluations, 21. Evaluation of Emergent Administrative Training Program Effectiveness.

1. As the Director of Clinical Education for the Skyline College Respiratory Therapy program and I would like to ask you based on our guided interview conversation involving my dissertation to grant me the permission to allow me to include you as one of my Respiratory Therapy profession professional contacts in my dissertation.

2. Please let me know if you feel my dissertation topic is a good idea, and if I have overlooked a topic that I should cover.

3. Please indicate if you have previously seen an administrative training program that can be given immediately in a PowerPoint presentation to the extent, I have developed for an Immediate Emergent Administrative Training Program for First-time RT Supervisors without prior supervisory experience.

4. Please let me know if you see any value for this Emergent Administrative Training program for the Skyline Respiratory Therapy program.

Irving

Appendix G
Brian Daniels response to Guided Interview

Daniel, Brian <danielb@smccd.edu>
Mon 12/14/2020 1:46 AM
To: You

Hello Mr. Spivey and thank you for including me in this important dissertation project. In my 35 years as respiratory care practitioner I realize the persistent lack of succession planning to respiratory care leadership and education. I believe your project could certainly fill this void.

I would like to learn more on how your project might be adapted specifically for aspiring educators in the field of respiratory care as there is currently nothing I have encountered that supports onboarding of tenure track respiratory care educators (nor clinical supervisory staff).

Let me know if you are looking to pilot this program in specific communities of respiratory care as we might be interested in Northern California's Bay Area.

Best regards.

Brian M. Daniel RRT, RCP
Director, Clinical Education
Respiratory Care Program

Skyline College
3300 College Drive
San Bruno, CA 94066
Office: 650-738-4180 Fax: 650-738-4299

www.SkylineCollege.edu
danielb@smccd.edu

Skyline College Mission: "To empower and transform a global community of learners."

Appendix H
Shawna Strickland response to Guided Interview

To Whom it May Concern,

I would like to submit as part of this project proposal that the American Association of Respirato ry (AARC) has expressed an interest in my dissertation project, and I am submitting the below e mail to confirm that.

Shawna Strickland <shawna.strickland@AARC.ORG>
Mon 11/23/2020 10:02 AM
To: You

Hi Irving

Thank you for your patience. Yes, you may use me as one of your professional contacts for your dissertation.

As we previously discussed, the AARC currently provides the Leadership Institute and is currently working on the Advanced Leadership Institute, which is similar in nature to your proposal. However, after your dissertation is completed, we can definitely talk about how this content may benefit AARC members and the AARC educational portfolio.

Shawna Strickland, PhD, CAE, RRT, RRT-NPS, RRT-ACCS, AE-C, FAARC
Associate Executive Director
9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063
Phone: 972-243-2272
(Pronouns: she/her)

Appendix I
Eugene Benjamin response to Guided Interview

Eugene Benjamin <eubenjam@montefiore.org>
Fri 12/18/2020 3:17 PM
To: You

Hello Irving

I have worked 40 in the RT profession with 25 plus year as a Respiratory Therapy manager, and I have been a Professor of Respiratory Therapy for New York University and Long Island University RT program for 20 years combined. I agree with you that the Administrative Duties of a Respiratory Therapy manager are not taught as part of an academic clinical Respiratory Therapy educational program, and I have never seen and immediate administrative training program to the extent that you have designed for first-time Respiratory Therapy Managers.

I also agree that the administrative skills of an RT manager's duties are learned over time by trial and error on-the-job after a first-time RT manager has accepted an appointment. I think your dissertation project is well overdue and is a good idea, and a presentation of this dissertation project in a PowerPoint presentation would be an assess to the RT profession and RT educational programs. I don't see anything else I would add to your dissertation project.

Ben

Eugene "Ben" Benjamin, BSRT
Director of Cardiopulmonary Care Services
Montefiore – New Rochelle, Mount Vernon, Schaffer Extended Care Center
16 Guion Place
New Rochelle, NY 10801
Office: (914) 365-3905
Cell: (914) 281-0717

Appendix J
Rosemary Williams response to Guided Interview

Rosemary Williams <rtrosey@gmail.com>
Fri 12/18/2020 2:36 AM
To: You

Hello Irving,

I have been in the Respiratory Therapy profession for 35 years of which 20 of those years were as a Respiratory Therapy Leader. I have also been a past Professor of Respiratory Therapy for the Kaplan College Respiratory Therapy program for 10 years. You are correct, the official administrative duties of a Respiratory Therapy manager are not taught as part of a clinical Respiratory Therapy program, and I have never seen an administrative training program like you have designed for first-time Respiratory Therapy supervisors. I consider your Dissertation project a good idea and I think it would also be a good program for recently hired RT supervisors within their first to four years of experience, that has never benefited from an administrative training program like you have developed.

It is true that the administrative duties of an RT supervisor are learned on-the-job and I think it is time that the RT profession integrate your dissertation topic in all Respiratory Therapy programs with a PowerPoint presentation. I don't see anything else I would add to your dissertation project.

Thank you for including me and Good Luck to you
Rosemary

Appendix K
Dr James Knight response to Guided Interview

Knight, James <James.Knight@nychhc.org>
Wed 10/21/2020 4:59 AM

To: You

Good Morning Irving,

After reviewing your statement of purpose I believe that you have selected a good topic for your dissertation. This is an area that is needed in health care today. It embarks on a new paradigm that is important particularly for individuals seeking a career in management. It takes “Train The Trainer” to a new level and should be added to every professional curriculum as well as every new orientation package in the job market today. I completely support your theory and proposal and look forward to seeing the completed work.

James A. Knight PhD RRT
Director, Respiratory Care\Nursing
Woodhull Medical and Mental Health Center

supplier' means a provider of services or supplier that owes a past-due obligation under the program under this title (as determined by the Secretary).

"(7) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.—

"(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

"(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or otherwise, of a temporary moratorium imposed under subparagraph (A).

"(8) COMPLIANCE PROGRAMS.—

"(A) IN GENERAL.—On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

"(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

"(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.".

(b) MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 4302(b), is amended—

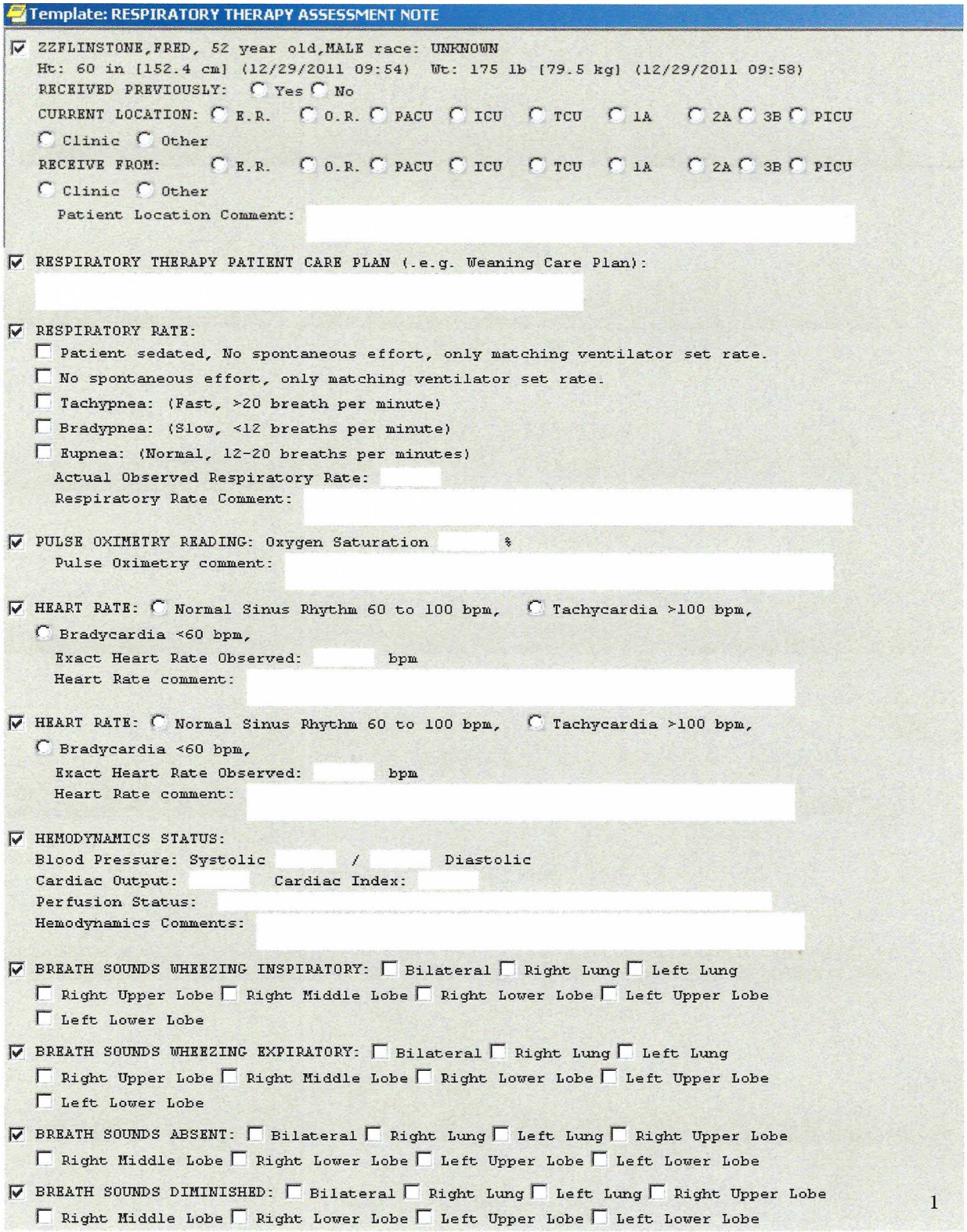
(A) in subsection (a)—

(i) by striking "and" at the end of paragraph (75);

(ii) by striking the period at the end of paragraph (76) and inserting a semicolon; and

(iii) by inserting after paragraph (76) the following:

Appendix M
Comprehensive Respiratory Therapy Template



Template: RESPIRATORY THERAPY ASSESSMENT NOTE

☑ ZZFLINSTONE,FRED, 52 year old,MALE race: UNKNOWN
Ht: 60 in [152.4 cm] (12/29/2011 09:54) Wt: 175 lb [79.5 kg] (12/29/2011 09:58)
RECEIVED PREVIOUSLY: ○ Yes ○ No
CURRENT LOCATION: ○ E.R. ○ O.R. ○ PACU ○ ICU ○ TCU ○ 1A ○ 2A ○ 3B ○ PICU
○ Clinic ○ Other
RECEIVE FROM: ○ E.R. ○ O.R. ○ PACU ○ ICU ○ TCU ○ 1A ○ 2A ○ 3B ○ PICU
○ Clinic ○ Other
Patient Location Comment:

☑ RESPIRATORY THERAPY PATIENT CARE PLAN (.e.g. Weaning Care Plan):

☑ RESPIRATORY RATE:
☐ Patient sedated, No spontaneous effort, only matching ventilator set rate.
☐ No spontaneous effort, only matching ventilator set rate.
☐ Tachypnea: (Fast, >20 breath per minute)
☐ Bradypnea: (Slow, <12 breaths per minute)
☐ Eupnea: (Normal, 12-20 breaths per minutes)
Actual Observed Respiratory Rate:
Respiratory Rate Comment:

☑ PULSE OXIMETRY READING: Oxygen Saturation %
Pulse Oximetry comment:

☑ HEART RATE: ○ Normal Sinus Rhythm 60 to 100 bpm, ○ Tachycardia >100 bpm,
○ Bradycardia <60 bpm,
Exact Heart Rate Observed: bpm
Heart Rate comment:

☑ HEART RATE: ○ Normal Sinus Rhythm 60 to 100 bpm, ○ Tachycardia >100 bpm,
○ Bradycardia <60 bpm,
Exact Heart Rate Observed: bpm
Heart Rate comment:

☑ HEMODYNAMICS STATUS:
Blood Pressure: Systolic / Diastolic
Cardiac Output: Cardiac Index:
Perfusion Status:
Hemodynamics Comments:

☑ BREATH SOUNDS WHEEZING INSPIRATORY: ☐ Bilateral ☐ Right Lung ☐ Left Lung
☐ Right Upper Lobe ☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Left Upper Lobe
☐ Left Lower Lobe

☑ BREATH SOUNDS WHEEZING EXPIRATORY: ☐ Bilateral ☐ Right Lung ☐ Left Lung
☐ Right Upper Lobe ☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Left Upper Lobe
☐ Left Lower Lobe

☑ BREATH SOUNDS ABSENT: ☐ Bilateral ☐ Right Lung ☐ Left Lung ☐ Right Upper Lobe
☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Left Upper Lobe ☐ Left Lower Lobe

☑ BREATH SOUNDS DIMINISHED: ☐ Bilateral ☐ Right Lung ☐ Left Lung ☐ Right Upper Lobe
☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Left Upper Lobe ☐ Left Lower Lobe

1

☑ BREATH SOUNDS DISTANT: ☐ Bilateral ☐ Right Lung ☐ Left Lung ☐ Right Upper Lobe
☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Left Upper Lobe ☐ Left Lower Lobe

☑ BREATH SOUNDS RHONCHI: ☐ Bilateral ☐ Right Lung ☐ Left Lung ☐ Right Upper Lobe
☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Left Upper Lobe ☐ Left Lower Lobe

☑ BREATH SOUNDS CRACKLES: ☐ Bilateral ☐ Right Lung ☐ Left Lung ☐ Right Upper Lobe
☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Left Upper Lobe ☐ Left Lower Lobe

☑ BREATH SOUNDS COARSE: ☐ Bilateral ☐ Right Lung ☐ Left Lung ☐ Right Upper Lobe
☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Left Upper Lobe ☐ Left Lower Lobe

☑ BREATH SOUNDS RALES: ☐ Bilateral ☐ Right Lung ☐ Left Lung ☐ Right Upper Lobe
☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Left Upper Lobe ☐ Left Lower Lobe

☑ BREATH SOUNDS CLEAR: ☐ Bilateral ☐ Right Lung ☐ Left Lung ☐ Right Upper Lobe
☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Left Upper Lobe ☐ Left Lower Lobe

☑ Audible breath sounds without stethoscope

☑ Breath sounds comments (e.g. Stridor, etc.):

☑ IRREGULAR RESPIRATORY BREATHING PATTERNS:

☐ Short and Shallow.
☐ Short and Fast.
☐ Apnea: No Breathing.
☐ Biot's: Irregular breathing with long periods of apnea.
☐ Cheyne-Stokes: Increase and decrease in depth and rate with periods of apnea.
☐ Kussmaul's: Deep and fast.
☐ Apneustic: Prolonged inhalation.
☐ Paradoxic: Part or all of chest wall moves in with Inhal. and out with Exhal.
☐ Asthmatic: Prolonged exhalation.

Respiratory Breathing Patterns Comment:

☑ PNEUMOTHORAX ASSESSMENT:
BREATH SOUND ABSENT: ☐ Right Upper Lobe ☐ Right Middle Lobe ☐ Right Lower Lobe
☐ Left Upper Lobe ☐ Left Lower Lobe
BREATH SOUND DIMINISHED: ☐ Right Upper Lobe ☐ Right Middle Lobe ☐ Right Lower Lobe
☐ Left Upper Lobe ☐ Left Lower Lobe
TRACHEA POSITION: ○ Normal ○ Deviation Left ○ Deviation Right

☑ PERCUSSION DULL: ☐ Right Upper Lobe ☐ Right Middle Lobe ☐ Right Lower Lobe
☐ Left Upper Lobe ☐ Left Lower Lobe

☑ PERCUSSION TYMPANIC: ☐ Right Upper Lobe ☐ Right Middle Lobe ☐ Right Lower Lobe
☐ Left Upper Lobe ☐ Left Lower Lobe

☑ CHEST TUBE STATUS: ☐ Right Side ☐ Left Side ☐ Center ☐ None

☑ Pneumothorax comment:

☑ CYANOSIS: ○ None ○ Central ○ Peripheral

Cyanosis comment:

☑ EDEMA STATUS: ☐ Pulmonary ☐ Central ☐ Peripheral ☐ Pitting ☐ None

Edema comment:

☑ PHYSICAL APPEARANCE:

- ☐ Excessive accessory muscle use
- ☐ Nasal flaring
- ☐ Cold Extremities
- ☐ Skin Cold and Clammy
- ☐ Skin Diaphoretic (Sweating)
- ☐ Finger Clubbing
- ☐ Chest Wall Retractions
- ☐ Barrel Chest: A/P diameter approximately equal to the lateral diameter.
- ☐ Pectus Carinatum:(Pigeon Chest) Sternal protrusion anteriorly
- ☐ Pectus Excavatum:(Funnel Chest) Depression of part or all of the sternum.
- ☐ Kyphosis: Abnormal Anteroposterior curvature
- ☐ Scoliosis: Abnormal lateral curvature
- ☐ Kyphoscoliosis: Combination of kyphosis and scoliosis

Physical Appearance comment:

☑ PHYSICAL IMPAIRMENT STATUS: ☐ Vision loss ☐ Hearing Impairment ☐ Speech Impairment

Comment:

☑ BODY MOVEMENT: ○ Active ○ Somewhat active ○ Very little ○ None

Body movement comment:

☑ PATIENT POSITION: ☐ Orthopneic ☐ Right side lying ☐ Left side lying

☐ Fowler's (Semi 45-degree) ☐ Fowler High ☐ Fowler Low ☐ Supine (flat on back)

☐ Prone (face down) ☐ Trendelenburg ☐ Reverse Trendelenburg ☐ Sitting Up ☐ Standing Up

Positioning comment:

☑ MENTAL STATUS:

- ☐ Confused: incoherent thoughts, slow mental responses.
- ☐ Delirious: easily agitated, irritable, hallucinations.
- ☐ Lethargic: responds easily and appropriately when aroused.
- ☐ Obtunded: awakens only with difficulty.
- ☐ Stuporous: does not awaken completely, slow to verbal stimuli.
- ☐ Comatose: no voluntary movement, no response to stimuli.
- ☐ Agitated: excessive restlessness, increased mental and physical.
- ☐ Oriented X3 to time, location and identity of person.
- ☐ Alert: responds quickly and appropriately.
- ☐ Patient sedated:
- ☐ Somnulent: sleepy.
- ☐ Drowsey: delayed and slow response.

Mental status comment:

☑ DYSPNEA EVALUATION: ○ Grade 0 None ○ Grade 1 Very Slight ○ Grade 2 Slight

○ Grade 3 Moderate ○ Grade 4 Somewhat Severe ○ Grade 5 Severe ○ Grade 6 Very Severe

○ Grade 7 Very Severe ○ Grade 8 Very Severe ○ Grade 9 Very, Very Severe

○ Grade 10 Maximal Severe Dyspnea

Dyspnea comment:

3

☑ COUGH ASSESSMENT: ☐ Not Attempted ☐ Chronic ☐ Croupy ☐ Dry ☐ Frequent ☐ Hacking
☐ Non-Productive ☐ Productive ☐ Strong ☐ Weak ☐ Other:
Cough Comment:

☑ SUCTIONING: ☐ Oral ☐ Nasal ☐ Trach ☐ Endotracheal
Suctioning Comment (indicate any adverse reactions):

☑ SECRETION STATUS Xl SUCTIONING:
AMOUNT: ☐ Scant ☐ Very Small ☐ Small ☐ Medium ☐ Large ☐ Copious
APPEARANCE: ☐ thick ☐ thin ☐ purulent ☐ green ☐ yellow ☐ white ☐ clear ☐ blood tinged
☐ very bloody ☐ brown ☐ odor
Secretion comment:

☑ SECRETION STATUS OVER 24 HOURS:
AMOUNT: ☐ Scant -- 1 to 5 ml/day ☐ Very Small -- 6 to 10 ml/day
☐ Small -- 11 to 15 ml/day ☐ Medium -- 16 to 20 ml/day ☐ Large -- 21 to 25 ml/day
☐ Copious -- >25 ml/day
APPEARANCE: ☐ thick ☐ thin ☐ purulent ☐ green ☐ yellow ☐ white ☐ clear ☐ blood tinged
☐ very bloody ☐ brown ☐ odor
Secretion comment:

☑ CHEST PHYSICAL THERAPY:
Duration:
Percussion Area:
Chest physical therapy comment:

☑ POSTURAL DRAINAGE:
Vital Signs before positioning:
HR:
RR:
BP:
Auscultation:
Position Ordered: ☐ Orthopneic ☐ Right side lying ☐ Left side lying
☐ Fowler's (Semi 45-degree) ☐ Fowler High ☐ Fowler Low ☐ Supine (flat on back)
☐ Prone (face down) ☐ Trendelenburg ☐ Reverse Trendelenburg ☐ Sitting Up ☐ Standing Up
Position duration:
Lobe(s)/Segments:
Pt Tolerance:
Vital Signs after positioning:
HR:
RR:
BP:
Postural drainage comment:

☑ SPUTUM INDUCTION: Date/Time:
AFB (X) Date:
CNS (X) Date:
OTHER SPUTUM TYPE INDICATE:
(X) Date:
Sputum induction Comment:

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☑ ISOLATION STATUS:

☐ Strict Isolation ☐ Contact Isolation ☐ Respiratory Isolation

☐ Tuberculosis (AFB) Isolation ☐ Enteric Precautions ☐ Drainage/Secretion Precautions

Isolation status comment:

☑ ABG STATUS:

Allen Test results: ○ Positive ○ Negative

Allen Test Comment:

○ ABG While Patient On Ventilator

○ ABG While Patient Off Ventilator

FIO2:

Frequency: Q Hrs.

Body Temp:

☐ On Room Air 21% ☐ Arterial line ☐ Needlestick ☐ ABG Unable to Obtain

ABG Comment:

☑ ABG INTERPRETATION STATUS:

○ Uncompensated ○ Partially compensated ○ Fully compensated

○ Metabolic Acidosis combined with, ○ Metabolic Alkalosis combined with,

○ Respiratory Acidosis, ○ Respiratory Alkalosis, CO2:[ ]mmhg

ABG Comment:

☑ MOST RECENT LAB RESULTS AT TIME OF NOTE (AUTOMATIC ENTRY):

ABG Comment:

☑ ABG MANUALLY ENTERED RESULTS:

pH:		PCO2:	
PaO2:		HCO3:	
BE:		Sat%:	

ABG Comment:

☑ BODY TEMPERATURE:

☐ Normal 97F to 100F or 36.1C or 37.8C ☐ Hyperthermia >100F or 37.8C

☐ Hypothermia <97F or 36.1C

Exact Body Temp Observed:

Body Temperature comment:

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☑ ABG PANIC VALUE (ENTERED MANUALLY) RESULTS:

		Reference Range	Critical Low	Critical High
pH:		(7.35 - 7.45)	< 7.251	> 7.599
PCO2:		(35 - 45 mmhg)	< 20.1	> 69.9
PaO2:		(70 - 100 mmhg)	< 50	
BE:				
HCO3:				
Sat%:				
NA:		(135 - 145 mmol/L)	< 125	> 155
K:		(3.5 - 5.0 mmol/L)	< 3	> 6
iCA:		(1.12 - 1.32 mmol/L)	< 0.75	> 1.55
GLUC:		(65 - 115 mg/dl)	< 50	> 400
HCT:		(42 - 52 %)		
HB:		(14 - 18g/dl)	< 7	

PANIC VALUES REPORTED TO MEDICAL DOCTOR (DATE & TIME):

☑ PATIENT TRANSPORT COMMENT:

☑ AIR MOVEMENT STATUS: ○ Good movement ○ Somewhat good movement
○ Moderate decrease in air movement ○ Very little air movement

☑ INCENTIVE SPIROMETER:
Frequency Q Hrs
Number of inspirations:
Volume measurement: ml/cc
Incentive Spirometry Comment:

☑ OFF VENTILATOR BEDSIDE SPIROMETRY (PFT) NOTE:
Date/Time:
Number of attempts:
Effort: ○ Poor ○ Fair ○ Good ○ Excellent

FVC: (L)	Actual=	%Pred=	Pred=		
FEV1: (L)	Actual=	%Pred=	Pred=		
FEV1/FVC: (%)	Actual=	%Pred=	Pred=		

ABG Results: pH: PCO2:
PO2: HCO3:
BE: spO2:
ABG Unable to obtain: ○ Yes ○ No
Beside PFT comment:

☑ PATIENT COMPLIANT FOR PFT(S): ○ Yes ○ No
Compliance comment:

☑ ON VENTILATOR PULMONARY FUNCTION TEST BEFORE EXTUBATION:
Date: Time:
Patient Compliance: ○ Yes ○ No
NIF: VC: MV:
RR:
On Ventilator PFT comment:

☑ PRE-EXTUBATION TRACHEAL LUMEN LEAK TEST: ☐ Passed ☐ Failed ☐ Md Notified

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☑ SPONTANEOUS BREATHING TRIALS CONTRAINDICATIONS:
☐ Not initiating spontaneous breaths ☐ PEEP >10CMH2O ☐ FIO2 >50% ☐ Unstable heart rhythm
☐ Hemodynamics unstable ☐ Temp. >30 degrees celsius ☐ Deeply sedated / paralyzed
Spontaneous breathing trial contraindications comment:

☑ SPONTANEOUS BREATHING TRIALS FAILURE:
☐ Short of Breath ☐ Diaphoresis ☐ Restlessness Agitation ☐ Increased Work of Breathing
☐ Decreased O2 Saturation ☐ High Respiratory Rate ☐ Increased Heart Rate
☐ Increase Blood Pressure ☐ Decrease Blood Pressure ☐ Increased ETCO2
Spontaneous breathing trial failure comment:

☑ METABOLIC CART ASSESSMENT STUDY:

☑ RESPIRATORY TREATMENT HOLD STATUS: ☐ Refused ☐ Held ☐ Not Given
Indicate Reason:

☑ RESPIRATORY MEDICATION TREATMENT(s):
☑ ACETYLCYSTEINE 20% INHL SOLN: Dosage , Frequency , Route VIA
☑ ALBUTEROL 3/IPRATROPIUM 0.5MG/3ML INHL 3ML: Dosage , Frequency , Route VIA
☑ ALBUTEROL 90/IPRATROPIUM 18MCG 200D PO INHL: Dosage , Frequency , Route VIA
☑ ALBUTEROL SO4 0.083% INHL 3ML: Dosage , Frequency , Route VIA
☑ ALBUTEROL 90MCG (CFC-F) 200D ORAL INHL:Dosage , Frequency , Route VIA
☑ CROMOLYN NA 800MCG 200D ORAL INHL: Dosage , Frequency , Route VIA
☑ FLUNISOLIDE 250 MCG 100D ORAL INHL: Dosage , Frequency , Route VIA
☑ FLUNISOLIDE 25 MCG 200 NASAL SPRAYS: Dosage , Frequency , Route VIA
☑ FLUTICASONE HPA INHL,ORAL 220/MCG/SPRAY: Dosage , Frequency , Route VIA
☑ FLUTICASONE PROP 50MCG 120D NASAL INHL:Dosage , Frequency , Route VIA
☑ FORMOTEROL FUMARATE 12MCG INHL CAP: Dosage , Frequency , Route VIA
☑ IPRATROPIUM BROMIDE 0.02% INH SOLN 2.5ML: Dosage , Frequency , Route VIA
☑ IPRATROPIUM BROMIDE 17MCG 200D ORAL INHL: Dosage , Frequency , Route VIA
☑ IPRATROPIUM BR 0.03% NASAL SPR 30ML/BTL Dosage: , Frequency , Route VIA
☑ LEVALBUTEROL TART 59MCG 200D ORAL INHL: Dosage , Frequency , Route VIA

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☑ METAPROTERENOL 650MCG 200D ORAL INHL: Dosage , Frequency , Route VIA

☑ MOMETASONE FUROATE 220MCG ORAL INHL 120: Dosage , Frequency , Route VIA

☑ SALMETEROL 50MCG / BLSTR PO INHL DISKUS: Dosage , Frequency , Route VIA

☑ SODIUM CHLORIDE 0.9% NEB SOLN,INHL: Dosage , Frequency , Route VIA

☑ SODIUM CHLORIDE 0.65% NASAL 45ML/BTL: Dosage , Frequency , Route VIA

☑ TIOTROPIUM 18MCG INHL CAP 30: Dosage , Frequency , Route VIA

☑ B/S before RT Tx:
B/S after RT Tx:
Heart Rate Before RT Tx:
Heart Rate after RT Tx:
O2 Saturation % in conjunction with RT Treatment
Comments:
Respiratory Rate Before RT Tx:
Respiratory Rate After RT Tx:
PRN Effectiveness:
Patient was on Ventilator: ○ Yes ○ No
○ No adverse reaction to Respiratory Medication :

☑ Respiratory Medication Treatment Comment(e.g. adverse reaction):

☑ PEAK FLOW:
Pre Bronchialdilator:
Post Bronchialdilator:
Number of Attempts:
Peak Flow comment:

☑ HELIUM / OXYGEN (HELI-OX) THERAPY:
Heli-Ox mixture percentage:
Delivery Device:
Supplemental Oxygen %:
Heli-Ox comment:

☑ NITRIC OXIDE ADMINISTRATION:
Date Started: Time Started:
Parts Per Million: PPM
PA Pressure: mmHg, Route of Delivery:
Nitric Oxide comment:

☑ PASSY-MUIR VALVE IN USE:
Comment:

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☑ OXYGEN DELIVERY DEVICE: Nasal Cannula _____ Lpm

☑ OXYGEN DELIVERY DEVICE: Simple Mask

☑ OXYGEN DELIVERY DEVICE: Oxy-Mask _____ Lpm _____ %

☑ OXYGEN DELIVERY DEVICE: Aerosol Mask _____ %

☑ OXYGEN DELIVERY DEVICE: Venturi Mask _____ %

☑ OXYGEN DELIVERY DEVICE: Tracheostomy Collar _____ %

☑ OXYGEN DELIVERY DEVICE: Face Tent _____ %

☑ OXYGEN DELIVERY DEVICE: T-Piece _____ %

☑ OXYGEN DELIVERY DEVICE: Partial Rebreather

☑ OXYGEN DELIVERY DEVICE: Non-Rebreather

☑ Patient on Room Air 21%

☑ Oxygen Delivery Device Comment:

☑ EzPAP (Positive Expiratory Pressure Therapy System):
Number of times: _____ Q
EzPAP comment:

☑ TheraPEP (Positive Expiratory Pressure Therapy System):
Number of times: _____ Q
TheraPEP comment:

☑ Acapella (Vibratory Positive Expiratory Pressure Therapy System):
Number of times: _____ Q
Acapella comment:

☑ Cough Assist Machine in use:
Number of times: _____ Q
Cough Assist Machine comment:

☑ NON-INVASIVE MECHANICAL VENTILATION:
☐ Bi-PAP ☐ CPAP ☐ IPPB
Ventilator #:
Mode:
Rate:
I:
E:
Observed Tidal Volume:
Minute Ventilation:
Face Mask type & size:
FIO2:
Lpm/FIO2: _____ %
Spontaneous rate:
Back-up rate:

☑ NON-INVASIVE VENTILATOR ALARMS: Low Press: _____ Audible: _____
Low Pressure Delay: _____ High Press: _____ Apnea: _____
Low Min. Vol: _____ High Min. Vol.: _____ High Rate: _____
Low Rate: _____ ☐ No Change in Ventilator Alarms

☑ Non-Invasive Mechanical Ventilation Comment:

☑ PATIENT INTUBATION:

Date: Time:

Patient Intubation Comment:

☑ ENDOTRACHEAL TUBE STATUS:

○ Oral ○ Nasal ○ Open Stoma

ET Size:

ET Tube Position at lip line:

RT Tube Location: ○ Left side ○ Middle ○ Right side

Facial Breakdown:

ET Tube Cuff Pressure:

Bite block: ○ Yes ○ No

ET Tube comment:

☑ TRACHEOTOMY STATUS:

Open stoma: ○ Yes ○ No

○ Trach Raw (Fresh) ○ Trach Old

Trach Size:

Trach Cuff Pressure:

Trach Style: ☐ Cuffed ☐ Cuffless ☐ Fenestrated ☐ Non-fenestrated ☐ Plastic ☐ Metal

☐ Trach Care ☐ Trach capped

Trach tube comment:

☑ INVASIVE MECHANICAL VENTILATION STATUS:

Mode: ☐ A/C ☐ SIMV ☐ PRVC ☐ PCV ☐ NAVA ☐ CPAP ☐ Vol. Sup. ☐ Auto Mode ☐ Bi-Level

☐ Tube Comp. ☐ CMV ☐ CPPV ☐ PLV ☐ Auto Flow ☐ IRV ☐ MMV ☐ PCV Plus ☐ PCV+(BiPAP)

☐ PCV+(BiPAP)/P. Support ☐ ARPV (Bi-Vent) ☐ ILV ☐ VC Plus ☐ PCAC/APV ☐ PCSIMV/APV ☐ ASV

Ventilator #:

Set Rate:

Spontaneous Rate:

TV:

FIO2:

PEEP:

PS:

PC:

I-Time (Ti):

I:E Ratio:

T Pause (sec.):

T Insp. rise (sec.):

Insp. cycle off%:

Trigger Time out (sec.):

Trigger Flow:

Trigger Pressure:

P.High:

T.High:

T.PEEP:

NAVA Level cmH2O/uV:

Trigger Edi: (0.5 default)

Ventilator circuit temp.:

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☑ INVASIVE VENTILATOR ALARMS: High Pressure: Low Pressure:
Audible: Low exhale tidal volume: Low Min. Vol:
High Min. Vol: High Respiratory Rate: Low Respiratory Rate:
Low PEEP/CPAP: High PEEP/CPAP: Apnea Time:
Units Capable For Setting Following Alarms, (e.g Vision):
☐ No Change in Ventilator Alarms

☑ Invasive mechanical ventilation comment:

☑ BACK UP MECHANICAL VENTILATION: ○ Invasive ○ Non-Invasive
PS:
Rate:
I:E Ratio:
I-Time (Ti):

☑ AIRWAY PRESSURE STATUS:
Plateau: Peak:
Auto PEEP:
Within acceptable limits: ○ Yes ○ No
Airway pressure comment:

☑ CHEST TUBE STATUS:

☑ PATIENT EXTUBATION OFF MECHANICAL VENTILATION:
Date: Time:
Patient extubation comment:

☑ RESPIRATORY THERAPIST'S COMMENT:

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Appendix N
American Telemedicine Association Practice Guidelines
Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK207144/

BOX 12-1 American Telemedicine Association Practice Guidelines

Completed	In Progress
• Teledermatology Quick Guides for Live-Interactive and Store and Forward • Telepresenting • Diagnosis of Diabetic Retinopathy • Telerehabilitation • Telemental Health: Video-Based Evidence-Based Telemental Health • Core Standards for Telemedicine Networks • Teledermatology • Home Telehealth • Telepathology	• Remote Prescribing • Desktop and Internet Telemental Health • Remote Health Monitoring Data Management • TeleUrgent/Primary Care • Tele-ICU • Telepathology • Telestroke • Teleradiology

SOURCE: Presentation by Stewart Ferguson, American Telemedicine Association.

From: 12, Stakeholder Perspectives

The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary.
Board on Health Care Services; Institute of Medicine.
Washington (DC): National Academies Press (US); 2012 Nov 20.

Appendix O
Table for the progressive penalties for Title 5 and Title 38 VA Employees

Department of Veterans Affairs
Washington, DC 20420

VA HANDBOOK 5021/15
Transmittal Sheet
July 19, 2013

EMPLOYEE/MANAGEMENT RELATIONS

1. REASON FOR ISSUE: To implement provisions of the "Government Charge Card Abuse Prevention Act of 2012" (Public Law 112-194, dated October 5, 2012) as it relates to penalties for misuse of purchase cards, convenience checks, and travel cards.

2. SUMMARY OF CONTENTS/MAJOR CHANGES: This handbook contains VA procedures on employee/management relations. The pages in this handbook replace the corresponding page numbers in VA Handbook 5021. Revised text is contained in [brackets]. These changes will be incorporated into the electronic version of VA Handbook 5021 that is maintained on the Office of Human Resources Management Web site. Significant changes include:

a. Adds a new penalty range to the Table of Penalties for failure to adhere to the rules governing the use of purchase cards, convenience checks and travel cards.

b. Establishes a consolidated Table of Penalties for all employees under title 5 and title 38. The revised table has been incorporated in Appendix A of parts I and II.

3. RESPONSIBLE OFFICE: The Employee Relations and Performance Management Service (051), Office of the Deputy Assistant Secretary for Human Resources Management.

4. RELATED DIRECTIVE: VA Directive 5021, Employee/Management Relations.

5. RESCISSIONS: None.

CERTIFIED BY:

/s/Stephen W. Warren
Acting Assistant Secretary for
Information and Technology

BY DIRECTION OF THE SECRETARY OF VETERANS AFFAIRS:

/s/Rafael A. Torres
Acting Assistant Secretary for
Human Resources and Administration

ELECTRONIC DISTRIBUTION ONLY

2. RANGE OF PENALTIES FOR STATED OFFENSES

NOTE: *'Days' specified in this table refer to [calendar days for suspension actions.*

TABLE OF PENALTIES FOR TITLE 5 AND TITLE 38 EMPLOYEES

NATURE OF OFFENSE	1ST OFFENSE	2ND OFFENSE	3RD OFFENSE
	Minimum to Maximum	Minimum to Maximum	Minimum to Maximum
Attendance			
1. Unexcused tardiness.	Admonishment Reprimand	Reprimand 7 days	7 days Removal
2. Unexcused or unauthorized absence.	Admonishment Reprimand	Reprimand 14 days	14 days Removal
3. Leaving job to which assigned or VA premises, during working hours, without proper permission.	Admonishment Reprimand	Reprimand 7 days	14 days Removal
4. Obtaining or requesting leave under false pretense, or falsifying attendance record for self or another employee.	Reprimand Removal	14 days Removal	Removal
Safety and Health			
5. Smoking in unauthorized places or carrying of matches in explosive areas.	Admonishment Reprimand	Reprimand 14 days	14 days Removal
6. Failure to report personal injury or accident.	Admonishment Reprimand	Reprimand 14 days	14 days Removal
7. Failure to observe precaution for personal safety, posted rules, signs, written or oral safety instructions; failure to use protective clothing or equipment; or carry flammable materials into a hazardous area.	Admonishment 14 days	Reprimand Removal	14 days Removal
8. Violating traffic regulations, reckless driving, or improper operation of a motor vehicle while on VA premises or in a duty status.	Admonishment 14 days	Reprimand Removal	14 days Removal
9. Endangering the safety of or causing injury to anyone on VA premises.	Admonishment Removal	14 days Removal	Removal
10. Abuse of patients or beneficiaries.	Reprimand Removal	14 days Removal	Removal

NATURE OF OFFENSE	1ST OFFENSE	2ND OFFENSE	3RD OFFENSE
	Minimum to Maximum	Minimum to Maximum	Minimum to Maximum
Information and Security			
11. Failure to safeguard confidential matter or access to such.	Admonishment Removal	Reprimand Removal	14 days Removal
12. Intentional falsification, misstatement, or concealment of material fact; willfully forging or falsifying official Government documents; or refusal to cooperate in an investigative proceeding.	Reprimand Removal	14 days Removal	Removal
13. Except as specifically authorized, disclosing or using direct or indirect information obtained as a result of employment in VA, which is of a confidential nature or which represents a matter of trust; or any other information so obtained of such character that its disclosure or use would be contrary to the best interests of the Government, VA, or the Veterans being served by it.	Reprimand Removal	Removal	
14. Violation of the Privacy Act, HIPAA or other laws, regulations and/or policy pertaining to information disclosure.	Reprimand Removal	14 days Removal	Removal
General Misconduct			
15. Loafing, willful idleness, or waste of time.	Admonishment Reprimand	Reprimand 14 days	14 days Removal
16. Careless or negligent workmanship resulting in waste or delay.	Admonishment Reprimand	Reprimand 14 days	14 days Removal
17. Sleeping on duty. a. Where safety of patients, beneficiaries, members, employees or property is not endangered. b. Where safety of patients, beneficiaries, members, employees, or property may be endangered.	 Admonishment Reprimand 7 days Removal	 Reprimand 14 days Removal	 14 days Removal
18. Deliberate failure or unreasonable delay in carrying out instructions.	Admonishment Reprimand	7 days 14 days	14 days Removal
19. Deliberate refusal to carry out any proper order from a supervisor having responsibility for the work of the employee; willful resistance to same.	Reprimand Removal	14 days Removal	Removal

NATURE OF OFFENSE	1ST OFFENSE	2ND OFFENSE	3RD OFFENSE
	Minimum to Maximum	Minimum to Maximum	Minimum to Maximum
General Misconduct			
20. Making false or unfounded statements, which are slanderous or defamatory, about other employees or officials.	Reprimand Removal	14 days Removal	Removal
21. Disrespectful, insulting, abusive, insolent, or obscene language or conduct to or about supervisors, other employees, patients, or visitors.	Reprimand Removal	14 days Removal	Removal
22. Fighting, threatening, attempting or inflicting bodily injury to another; engaging in dangerous horseplay. **NOTE:** *Penalty depends on such factors as provocation, extent of any injuries, and whether actions were defensive or offensive in nature.*	Reprimand Removal	14 days Removal	Removal
Alcohol and Drug Related			
23. Offenses related to intoxicants. a. Alcohol-related:			
(1) Unauthorized possession of alcoholic beverages while on VA premises.	Reprimand 7 days	14 days Removal	Removal
(2) Unauthorized use of alcoholic beverages while on VA premises.	Reprimand 14 days	14 days Removal	Removal
(3) Reporting to or being on duty while under the influence of alcohol.	Reprimand Removal	14 days Removal	Removal
(4) Sale or transfer of an alcoholic beverage while on VA premises or in a duty status, or while any person involved is in a duty status.	14 days Removal	Removal	

NATURE OF OFFENSE	1ST OFFENSE	2ND OFFENSE	3RD OFFENSE
	Minimum to Maximum	Minimum to Maximum	Minimum to Maximum
Alcohol and Drug Related			
b. Drug-related: (1) Possession of an illegal drug or unauthorized possession of a controlled substance while on VA premises. (2) Unauthorized use of an illegal drug or controlled substance while on VA premises. (3) Reporting to or being on duty while under the influence of an illegal drug or unauthorized controlled substance. (4) Sale or transfer of an illegal drug or controlled substance while on VA premises or in a duty status, or while any person involved is in a duty status. (5) Refusal to take drug test. **NOTE:** *For offenses relating to VA's Drug-Free Workplace Program, see VA Directive and Handbook 5383.*	7 days Removal 14 days Removal 14 days Removal 14 days Removal Removal	14 days Removal Removal Removal Removal	Removal
Outside Activities / Financial Interest			
24. Indebtedness; lack of good faith in paying just financial obligations.	Admonishment	Admonishment Reprimand	Reprimand Removal
25. Participation in any type of outside activities, of relationships with contractors, lenders, builders, or others engaged in business with VA, or relationships with those seeking contracts, which would be contrary to the best interests of VA and the Veterans it serves. **NOTE:** *Penalty action will be determined on the basis of whether the activities, or relationships, might result in a conflict between the private interest of the employee and his/her duty and obligation to VA, or tend to create in the minds of others a suspicion of prejudice or favoritism that would be of embarrassment to VA.*	Admonishment Removal	14 days Removal	Removal

NATURE OF OFFENSE	1ST OFFENSE	2ND OFFENSE	3RD OFFENSE
	Minimum to Maximum	Minimum to Maximum	Minimum to Maximum
Outside Activities / Financial Interest			
26. Gambling, unlawful betting, or the promotion thereof, on VA premises.	Reprimand 14 days	14 days Removal	Removal
27. Participating in a strike, work stoppage, sick-out, slowdown, or other job action.	Reprimand Removal	Removal	
28. Borrowing from, or lending money to, any beneficiary or claimant of VA; or borrowing from, or lending money to, another VA employee (or non-VA employee) for the purpose of monetary gain while on duty or on VA property.	Reprimand Removal	Removal	
29. Soliciting contributions for, or otherwise promoting, on premises occupied by VA, of any type of campaign which has not had appropriate VA endorsement.	Reprimand Removal	14 days Removal	Removal
30. Selling tickets, stocks, articles, or commodities or services on VA premises that has not had appropriate VA endorsement.	Reprimand Removal	14 days Removal	Removal
31. Accepting gifts or gratuities (whether in the form of goods, money, services, purchases at discount, entertainment, or similar favors) from claimants or beneficiaries of VA, or individuals or firms doing business with or having contractual relations with VA.	Reprimand Removal	Removal	
32. Owning any interest in, or receiving any wages, salary dividends, profits, gratuities, or services from any educational institution operated for profit in which an eligible Veteran, or person, is pursuing a course of education or training under 38 U.S.C. 34 and 35, where it is determined that detriment will result to the United States or to eligible Veterans, or persons, by reason or such interest or connection.	Removal		

NATURE OF OFFENSE	1ST OFFENSE	2ND OFFENSE	3RD OFFENSE
	Minimum/ Maximum	Minimum/ Maximum	Minimum/ Maximum
Use of Government Property			
33. Loss of, damage to, or unauthorized use of Government property:			
a. Through carelessness or negligence	Admonishment 14 days	14 days Removal	Removal
b. Through maliciousness or intent	Reprimand Removal	14 days Removal	Removal
34. Actual or attempted removal of Government property or other property from VA premises.	Reprimand Removal	14 days Removal	Removal
Discrimination / EEO / Protected Activity			
35. Sexual harassment.	Reprimand Removal	7 days Removal	14 days Removal
36. Discrimination based on race, color, sex, religion, national origin, age, marital status, political affiliation, or disability.	Reprimand Removal	7 days Removal	14 days Removal
37. Interference with an employee's exercise of, or reprisal against an employee for exercising, a right to grieve, appeal or file a complaint through established procedures.	Reprimand Removal	7 days Removal	Removal
38. Reprisal against an employee for providing information to an Office of Inspector General (or equivalent) or Office of Special Counsel, or to an EEO investigator, or for testifying in an official proceeding.	14 days Removal	Removal	
39. Reprisal against an employee for exercising a right provided under 5 U.S.C. 71 (Federal Labor Management Relations Statute).	Reprimand Removal	7 days Removal	14 days Removal
40. Violation of an employee's constitutional rights (i.e., freedom of speech, association, religion).	Reprimand Removal	7 days Removal	14 days Removal

NATURE OF OFFENSE	1ST OFFENSE	2ND OFFENSE	3RD OFFENSE
	Minimum/ Maximum	Minimum/ Maximum	Minimum/ Maximum
Offenses Prescribed in Statute			
41. Failure to adhere to the rules governing the use of Government charge cards (purchase, travel, or fleet) and convenience checks.	Admonishment Removal	7 days Removal	14 days Removal
42. Prohibited personnel practice (5 U.S.C. 2302).	Reprimand Removal	14 days Removal	Removal
43. Willfully using or authorizing the use of Government passenger motor vehicle or aircraft for other than official purposes (31 U.S.C. 1349(b)).	30 days Removal	Removal	
44. Finding by MSPB of refusal to comply with MSPB order or of violation of statute causing issuance of Special Counsel complaint ((5 U.S.C. 1204(a)(2) and 1212(a)). **NOTE:** *Penalty may need to be coordinated with Office of Special Counsel.*	Reprimand Removal	7 days Removal	14 days Removal
45. Prohibited Political Activity: a. Violation of prohibition against the solicitation of political contributions (5 U.S.C. 7323). b. Violation of prohibition against influencing elections (5 U.S.C. 7324). **NOTE:** *Actions based on Hatch Act violations will be initiated by the Office of Special Counsel.*	Removal 30 days Removal	Removal	
46. Soliciting contributions for a gift for a superior; making a donation as a gift to a superior; accepting a gift from an employee receiving less pay (5 U.S.C. 7351).	Reprimand Removal	14 days Removal	Removal
47. Directing, expecting, or rendering services not covered by appropriations (5 U.S.C. 3103).	Removal		
48. Failure to deposit into the Treasury money accruing from lapsed salaries or from unused appropriations for salaries (5 U.S.C. 5501).	Removal		

NATURE OF OFFENSE	1ST OFFENSE	2ND OFFENSE	3RD OFFENSE
	Minimum/ Maximum	Minimum/ Maximum	Minimum/ Maximum
Offenses Prescribed in Statute			
49. Action against national security (5 U.S.C. 7532).	30 days Removal	Removal	
50. Mutilating or destroying a public record (18 U.S.C. 2071).	Removal		

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