



Montana Department of LABOR & INDUSTRY

Governor Steve Bullock
Commissioner Pam Bucy

Business Standards Division -

Board of Respiratory Care Practitioners

BOARD ADVISORY ON ADVANCED LIFE SUPPORT PROTOCOLS AND SCOPE OF PRACTICE FOR RCP LICENSEES

August 21, 2012 / February 19, 2013

The Montana Board of Respiratory Care Practitioners has been advised that respiratory therapist departments at Montana hospitals have been told that Montana RCP licensees no longer may be providers of Advanced Cardiovascular Life Support and/or Pediatric Advanced Life Support.

The Board disagrees with the assertion that RCP licensees may not provide ACLS or PALS and first made a motion at its August 21, 2012 meeting regarding this subject:

MOTION: Tony Miller moved to have the Department draft a letter to those inquiring about emergency services that it is within respiratory care practitioners' scope of practice to use known protocols to deliver emergency care under 37-28-102(3)(a)(v) MCA and ARM 24.213.301(1). Leonard Bates seconded. Motion carried.

The Board subsequently moved at its February 19, 2013 meeting to expand that directive and make clear that RCP scope of practice includes the following protocols:

- *Advanced Cardiovascular Life Support (ACLS)
- *Pediatric Advanced Life Support (PALS)
- *Neo-natal Resuscitation Protocol (NRP)

Both the relevant statute and rule are cited below:

FROM THE MONTANA CODE ANNOTATED:

37-28-102. Definitions. As used in this chapter, the following definitions apply:

(1) "Board" means the board of respiratory care practitioners established in 2-15-1750.

(2) "Qualified medical direction" means the direction of:

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(a) a medical director of an inpatient or outpatient respiratory care service, a respiratory care department, or a home-care agency; or

(b) a licensed physician with a special interest and knowledge about the diagnosis and treatment of respiratory problems.

(3) (a) "Respiratory care" means the care provided by a member of the allied health profession responsible for the treatment, management, diagnostic testing, and control of patients with deficiencies and abnormalities associated with the cardiopulmonary system. The term includes but is not limited to:

(i) administration of pharmacological, diagnostic, and therapeutic agents related to respiratory care procedures that are necessary to implement a treatment, disease prevention, pulmonary rehabilitative, or diagnostic regimen prescribed by a physician;

(ii) transcription and implementation of the written or verbal orders of a physician regarding the practice of respiratory care;

(iii) observation and monitoring of a patient's signs and symptoms, general behavior, and physical response to respiratory care treatment and diagnostic testing, including determination of abnormal characteristics;

(iv) implementation of respiratory care protocols pursuant to a prescription by a physician; and

(v) initiation of emergency procedures prescribed by board rules.

(b) Respiratory care is not limited to a hospital setting but must be performed pursuant to a physician's order and under qualified medical direction. The term includes inhalation and respiratory therapy.

FROM THE ADMINISTRATIVE RULES OF MONTANA:

24.213.301 DEFINITIONS

(1) The board defines "emergency procedures" as that term is used in 37-28-102 , MCA, to include, but not be limited to, known and physician-approved protocols relating to life-sustaining procedures in emergency situations in the absence of the immediate direction of a physician. Emergency respiratory care may also be provided during transportation of a patient and under any circumstances where an epidemic, public disaster or other emergency necessitates respiratory care.

(2) For the purposes of 37-28-102 (3)(a), MCA, "respiratory care" does not include the delivery, assembly, testing, simulated demonstration of the operation or demonstration of safety and maintenance of respiratory therapy equipment by home medical equipment ("HME") personnel to a client's home, pursuant to the written prescription of a physician. "Respiratory care" does include any instruction to the client

regarding clinical use of the equipment, or any monitoring, assessment or other evaluation of therapeutic effects.

(3) The board defines "clinical supervision" as the availability of a licensed respiratory care practitioner for purposes of immediate communication and consultation.

(4) The board defines "pulse oximetry," "pulmonary function testing" and "spirometry" as diagnostic procedures that, pursuant to the orders of a physician, may be performed only by, or under clinical supervision of, a licensed respiratory care practitioner and/or other licensed health care provider who has met the minimum competency standards. The individual performing pulmonary function testing and spirometry must meet minimum competency standards, as they currently exist, as established by the National Institute for Occupational Safety and Health (NIOSH) or the National Board for Respiratory Care (NBRC) certification examination for entry level respiratory therapist, certification examination for entry level pulmonary function technologist (CPFT) credential or registry examination for Advanced Pulmonary Function Technologists (RPFT) specific to pulmonary function testing.

(5) The board defines "formal pulmonary function testing" to include, but not be limited to:

- (a) diffusion capacity studies; and
- (b) complete lung volumes and flows.

(6) The board defines "informal screening spirometry" to include, but not be limited to:

- (a) peak expiration flow rate;
- (b) screening spirometry forced expiration volume for one second;
- (c) forced vital capacity; and
- (d) simple vital capacity.

History: Sections (2) and (3) are advisory only, but may be a correct interpretation of the law, 37-28-104, MCA; IMP, 37-28-101, 37-28-102, MCA; NEW, 1992 MAR p. 913, Eff. 5/1/92; AMD, 1994 MAR p. 160, Eff. 1/28/94; AMD, 1994 MAR p. 668, Eff. 4/1/94; AMD, 1997 MAR p. 542, Eff. 3/25/97; AMD, 2000 MAR p. 1039, Eff. 4/28/00; AMD, 2001 MAR p. 1096, Eff. 6/22/01; TRANS, from Commerce, 2003 MAR p. 1286; AMD, 2005 MAR p. 453, Eff. 4/1/05.