Registered respiratory therapists as force multipliers in interprofessional complex continuing care

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Many acute care hospital access and flow challenges are attributable, in part, to inadequate resources for complex care clients outside of acute care hospitals. In the current issue of the *Journal*, Nickerson (1) (pages 55-59) describes multifactorial and mixed methods research to determine respiratory therapy care needs in complex continuing care (CCC). The author concludes "The burden of respiratory disease is significant, and includes a high prevalence of inhaled medication and oxygen use and a significant workload attributed to the respiratory needs of patients."

Although there are no simple methods or answers, this is important foundational work. CCC registered respiratory therapist (RRT) staffing has not received much attention, and that should change (2,3).

Guidelines for appropriate staffing ratios for RRTs working in critical care units have been described; however, no such guideline exists for CCC units. Even when such guidelines exist, Nickerson (1) points out that a staffing ratio does not necessarily reflect the suitability of patient care, and that "system level stressors are best identified at the bedside."

FORCE MULTIPLIERS

In military parlance, a force multiplier refers to an attribute or a combination of attributes that make a given force more effective than that same force would be without it. A force multiplier can increase the effectiveness of a group.

A challenge for RRTs will be to learn more about the growing spectrum of other care providers in CCC, including physiotherapists, occupational therapists, social workers, licensed practical nurses, health care aides and rehabilitation assistants who have traditionally shared responsibility for chronic disease care plan interventions (2-9).

RRTs will need to look beyond tasks, to codesign processes that enable respiratory services to work synergistically with these groups. A resilient, flexible approach may be more useful than rigid attempts to carve out definitive RRT roles. These RRTs will be integral system components for education, mentorship and knowledge translation within a truly integrated multidisciplinary community service team.

There are some examples to look to, including Red Eagle Ridge (Norwood) in Edmonton, Alberta (8), and the Freeport site of Grand River Hospital, in Kitchener, Ontario (9). The RRT skill set can be a force multiplier in chronic care. Perhaps the article by Nickerson (1) will be an impetus for RRTs to offer their services in CCC facilities for a skill mix that better addresses these complex care needs.

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