Deadline for applications is December 15 Annually

Application for Annual Award of

***Hospital of the Year** for Respiratory Care*
presented by: Louisiana Society for Respiratory Care

Application criteria:

- Respiratory Care Services must be provided by personnel who obtain the CRT or RRT credentials.
- Facility must be able to provide some type of proof/confirmation of claims if requested by judging panel.
- The application must be signed by the Respiratory Therapy Department Manager, and the Hospital/Facility CEO.

Award breakdown:

Two awards will be given:

- < 200 bed facility
- > 200 bed facility

The following categories will be judged

- % of staff with RRT credential
- % of staff that are AARC members(Please provide AARC numbers and Renewal dates)
- % of staff with specialized credentials/certificates (ACLS, PALS, NRP, NPS, CPFT, RPFT, etc)
- Presence & use of Therapists Driven Protocols
- Blood Gas Lab Efficiency and Safety (Turnaround times, Latest CAP/JC inspection, # of analytes accredited for)
- Services offered at facility under the Respiratory Therapy Department
- % of staff maintaining advanced competency procedures/equipment and therapy
- Retention rate of respiratory therapy department
- Professional relationships and effective communication amongst all team members caring for pulmonary patients
- Community Outreach opportunities, health fairs etc.
- Smoking Cessation Clinics offered
- Clinical site for Respiratory Therapy Students
- If you are a past HOTY recipient the judging will include proof of improvement

Judging will be done in a manner that is non-biased. The judging committee will not be aware of any identification of the facility at the time of judging. You may send your entry electronically to the Award Collections Committee at melrrt45@gmail.com then mail your signed entries to Melissa Smith at 261 Empress Court Madisonville, LA 70447.

All therapist driven protocols must accompany the application (preferably electronic). A list of respiratory therapists in your department with credentials and AARC member numbers must accompany your application for the validation committee's use. This information will ONLY be used for validation purposes.

The award recipients will be honored and recognized at the LSRC annual conference, and will be given free admission for two to the conference.

Deadline for applications is December 15 Annually

For questions, please contact your Chapter President or Melissa Smith @ 225.610.4540 or by the above email address.

Deadline for applications is December 15 Annually

Hospital of the Year Award
for Respiratory Care

Name of Facility ____

Number of Licensed beds

- € 200 beds or more
- € Less than 200 beds

Address of facility____

In what Chapter of the LSRC is your facility located?

- € Chapter 1
- € Chapter 2
- € Chapter 3
- € Chapter 4
- € Chapter 5
- € Chapter 6
- € Chapter 7
- € Chapter 8
- € Chapter 9

Name of Person submitting the Application __ ________

Contact phone number _____________**Email address** _____________________

At your facility, Respiratory Care Services are provided by personnel that hold the credential of (mark all that apply)

- € RRT
- € CRT
- € RN
- € LPN
- € Lab tech
- € Phlebotomist

Number of Respiratory Therapists within the department _________

Deadline for applications is December 15 Annually

Please answer the following questions with honesty and accuracy regarding the Respiratory Therapy Services. Documentation of claims may be requested by the judging panel for validation. Names of staff members may also be requested to verify AARC membership and NBRC credentialing status.

RRT Credentials

1. Does your department have a process to encourage CRT's to test for the RRT exam?
   - € Yes
   - € No

   If so, please briefly describe.
   ____
2. What is the % of staff that holds the RRT credential? ______

AARC Membership

1. Does your department encourage/provide incentives for becoming and maintaining AARC membership?
   - € Yes
   - € No
2. If so, please briefly describe. ____
3. What % of staff are AARC members? _____________________________

Specialized Credentials/Certifications

1. Does your department have a process/incentive to encourage or require staff to maintain advanced credentials
   - € Yes
   - € No
2. If so, please briefly describe.
   ____-What % of staff holds and maintains the following credentials/certifications? (mark all that apply)
   - € NPS __%
   - € CPFT ______%
   - € RPFT ______%
   - € Asthma-ed ______%
   - € ACLS ______%
   - € PALS ______%
   - € NRP ______%
   - € Other:____%

Therapist Driven Protocols

1. Does your department follow Therapist Driven Protocols to manage patients with Pulmonary Disease? (this is not the same thing as an order set)
   - € Yes
   - € No

2. Please list all Therapist Driven Protocols that you use.
   - € ____
   - € ________________ ________________________
   - € ____
   - € ____
   - € ____
   - € ____
   - € ____
3. What were the outcomes at your facility by instituting the TDP?

____A copy of each protocol must be submitted with application (preferably electronic).

Blood Gas Lab Management

1. Does the Respiratory Therapy Department manage the ABG lab?
   - € Yes
   - € No
2. Who are you accredited by?
   - € CAP
   - € Joint Commission
3. What analytes does your lab provide? (mark all that apply)
   - € pH
   - € pCO2
   - € pO2
   - € K+
   - € Na+
   - € Cl-
   - € Mg++
   - € Ca++
   - € Glucose
   - € BUN
   - € Creatinine
   - € Total Hgb
   - € COHb
   - € metHb
   - € Others: _____________

Services Offered

1. Please mark all services provided by the Respiratory Therapists in your department. (mark all that apply)
   - € Basic Floor Care
   - € Adult ICU
   - € Pediatric ICU
   - € Neonatal ICU
   - € Emergency Care
   - € Sleep Lab
   - € EKG
   - € EEG
   - € Transport team
   - € ECMO
   - € Pulmonary Rehab
   - € Smoking Cessation Program
   - € PFT
   - € Rapid Response Team

Deadline for applications is December 15 Annually

- € Clinical Instruction for Students
- € Other: ____

Advanced Competencies

1. Which of the following competencies are present in your department? And What % of staff are "checked off" on each competency? (mark all that apply)
   - € Intubation ______%
   - € Insertion of Arterial Line _____%
   - € High Frequency Ventilation ______%
   - € Nitric Oxide ______%
   - € Bronchoalveolar Lavage ___%
   - € Other: ____________________ ______%
   - € Other: ____________________ ______%

Retention Rate

1. Briefly describe administrative and/or departmental decisions made to make the work place a pleasant environment for the staff caring for patients with pulmonary disorders.
   ____
   ____
2. What is the retention rate for the respiratory department staff? ______ Entire hospital? _***%***____

Professionalism and Teamwork

1. Does the respiratory therapy staff work efficiently and professionally with all team members that provide services for patients with pulmonary disorders? (Ex: physicians, nurses, etc.)
   - € Yes
   - • No
2. Briefly describe daily actions/encounters of outstanding professionalism and teamwork amongst all health care providers for patients with pulmonary disorders***:***________________

Community Outreach

1. Does your Respiratory Care Department participate in Community Outreach Programs, such as health fairs, high school career days etc.?
   - • Yes
   - • No

   ____
   ____
   ____
   ____
   ____

Smoking Cessation Clinics Offered

Does your facility offer smoking cessation clinics to your patients? Are they provided by Respiratory Therapists?

- € Yes
- € No

____
____
____
____

Clinical Site for Respiratory Therapy Students

- Yes
- No

What programs?

____
____
___

Previous HOTY recipients please provide information about the improvements to your department since you last received this award:

____
____
____
____
____
____
____

The signed below verifies that the information provided in this application is accurate.

____ ______________

Person Submitting Application (sign name/print name
Date

____ ______________

Deadline for applications is December 15 Annually

Respiratory Therapy Director/Manager (sign name/print name) Date

_______________________________________ _____________

CEO (sign name/print name) Date