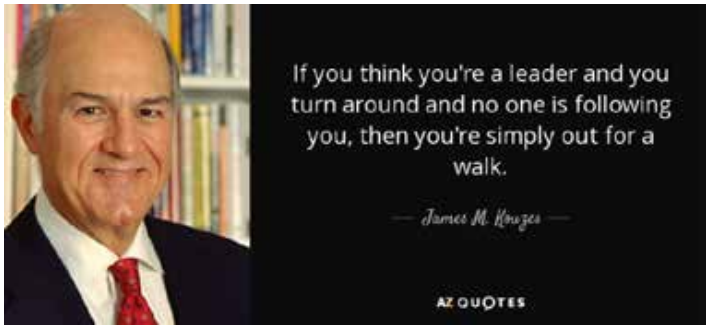
Peer Reviewed

Respiratory Therapy Leadership

Kelly Lewis, BA, RRT-NPS



At a recent California Society for Respiratory Care meeting, it was brought up that both the Respiratory Care Board and the CSRC would like to see more training for Respiratory Therapists on leadership.

This month, the RCB in California changed the continuing education requirements to include courses in leadership and communication, as well as granting credit for attending certain upper-level meetings.

"According to some experts in the field of RT education (who have been around for a while), there is a shortage of RTs prepared for leadership. Leadership is an umbrella term that covers many different jobs within a hospital organization."

According to some experts in the field of RT education (who have been around for a while), there is a shortage of RTs prepared for leadership. Leadership is an umbrella term that covers many different jobs within a hospital organization.

Leadership can consist of the CEO, COO, CFO, and anyone else in hospital administration. Leadership principles apply to managers, supervisors, classroom and clinical educators, and shift leads.

"Some hospitals have their own 'Management University'. There you will learn the subtle differences between a manager and a leader. A manager's job is to make sure. Ensure everyone's timecard is complete, the schedule is done, and annual competencies are attended to and documented."

Some hospitals now require RT department heads to have a master's degree.

However, having a Bachelor's or Master's does not automatically make one a leader. Some people seem to be made of leadership material, and others studied hard and grew into a position that commanded respect.

Some hospitals have their own 'Management University'. There you will learn the subtle differences between a manager and a leader. A manager's job is to make sure. Ensure everyone's timecard is complete, the schedule is done, and annual competencies are attended to and documented.

A leader's job is to drive a group of people, such as an RT department, to do better and greater things. To inspire others to think bigger. A leader's job is to encourage solutions and ideas that will benefit all parties involved, and a truly great leader will have other hospitals noticing the impact he or she has made on the staff and the bottom line. A leader's job is to get people to think of how things can be done more cost-efficiently, in a more streamlined manner, more productively, and more satisfying to the staff and the patients. A shift lead or supervisor is there to ensure the shift runs smoothly, that the workload is balanced, and that the next shift can handle the workload with the scheduled number of RTs on.

"A leader's job is to encourage solutions and ideas that will benefit all parties involved, and a truly great leader will have other hospitals noticing the impact he or she has made on the staff and the bottom line. A leader's job is to get people to think of how things can be done more cost-efficiently, in a more streamlined manner, more productively, and more satisfying to the staff and the patients."

All three titles (manager, supervisor, and leader) must work together well. With so much management and making sure, a ther-

apist or even an entire department must *want* to do better and greater things, and a leader is the person who will help expand roles and create opportunities for RTs to practice to the fullest extent of our licenses.

However, so many managers are nearly invisible to staff. Meetings upon meetings, doors closed, work to do, Administration and C-Suite to answer to, who has time to schmooze with staff and think of things to expand The RT's capabilities?

Many hospitals have turned to Unit-based teams and similar ideas, such as Shared Decision-making councils, to get staff involved in problem-solving and building a better department.

"Many well-intentioned managers and leaders have tried to make this a fun and creative day at work for the staff, but without anyone from leadership – or anyone with a Leadership mindset taking part in the discussions, solutions brought to administration are often shot down for reasons staff cannot understand. "

Many well-intentioned managers and leaders have tried to make this a fun and creative day at work for the staff, but without anyone from leadership – or anyone with a Leadership mindset taking part in the discussions, solutions brought to administration are often shot down for reasons staff cannot understand. Moreover, staff who cannot speak freely on a topic stay quiet. That means back to square one.

Here is one example of how Shared Decision Making (SDM) can backfire:

Consider this lesson #1 in leadership.

Hospital A has a department of 48 staff RTs and 3 Pulmonary Rehab/PFT staff. They have been unable to get one meeting, mainly due to their staffing mix. There are 25-day shift RTs and 20 night shifters. Twenty of the day shifts are full-time, five are per diem. 13 night shifters are full-time, and seven are per diem.

At first glance, 25 people on a day seems like plenty to pull from for a rousing good meeting. Nevertheless, the average day requires 7 RTs, the shift lead, a PFT person, the Pulmonary Rehab people, the ABG coordinator, and the Educator.

13 RTs are there to take care of patients. That leaves 12 people to meet and get stuff done, right? What no one took into account is:

- Not all 25 want to be on SDM
- Many of them had a second job taking up two days a week
- If a meeting was to take place on their day off, they had families and kids and sports and laundry, which was technically their day off.

The night shift did not want to be left out but did not want to come in early or stay late for a daytime meeting.

Management tried to schedule an SDM meeting with the RTs on duty on a particular day. Pagers beeping, overheads calling codes, and sick calls coming in - herding cats seemed to be a good descriptor for that meeting. Hospital A called in a regional SDM coordinator to help schedule this SDM meeting, as Nursing was forever boasting in manager meetings how they have replaced their staff meetings with SDM workdays, with no problem simultaneously staffing their units.

"The coordinator, a lovely new grad MBA, looked at the staff schedule and determined she could pull an uninterruptable meeting together. It never occurred to her that people might be unavailable on their day off. Taking a hard line, she mandated that certain people would attend and contribute to these meetings."

The coordinator, a lovely new grad MBA, looked at the staff schedule and determined she could pull an uninterruptable meeting together. It never occurred to her that people might be unavailable on their day off. Taking a hard line, she mandated that certain people would attend and contribute to these meetings. When Miss MBA was told that staff would NOT be quitting their other per diem job to accommodate Hospital A and that per diem jobs had a minimum availability requirement, she was stunned. She met with almost the entire RT staff and was dumbfounded to learn how hard and how much RTs work. How was it that this was so easy with nursing? It was pointed out to her that nursing salaries are generally higher than RT salaries, often allowing RNs to work just one job and add overtime as needed.

Moreover, she was just as shocked to learn how much RTs were in demand. Each meeting with an RT was interrupted by several pages and overheads. Furthermore, she was even more shocked to learn that RT's covered the entire hospital.

Discussion:

How could leadership have remedied this? Hospital A's smaller sister hospital, with a much smaller staff and much lower acuity, managed to get their SDM happening, complete with project ideas and cost savings.

When it came time to present to upper management what the project and results were for Hospital A, the manager had no choice but to send the ABG coordinator and the shift lead to man a table for 2 hours to showcase the department's big plan to save money by doing something they had already been doing.

How would you have handled this situation?

Next month: Leadership case study for Hospital B.

About the author:

Having spent most of my career as an RT Clinical Educator, my positions were technically management, with one foot in leadership and one foot in the clinical setting. I learned a LOT about leadership and management over the years.

Why didn't I ever get my BSRT? Short answer, I made it a point to learn something new daily.

I thought about PA school, but that would make me leave my job

– which I loved. Next thing, 40 years had gone by. I believe there is a lot to be said for experience. Nevertheless, I will tell any newcomer to the RT field to get a BSRT. Furthermore, learn something new every day.

Disclosure: The author has no disclosures.

NT

Corresponding Author

--
Kelly Lewis, BA, RRT-NPS
President,
Academy of Neonatal Care
La Quinta, California, United States
Website: www.AcademyofNeonatalCare.org
Phone: 877-884-4587
Email: Educator@academyofneonatalcare.org