

# Readiness of Respiratory Therapists for High-Acuity Patient Management in Hospital Settings

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## ABSTRACT

This study assessed the readiness of respiratory therapists for high-acuity patient management in hospital settings, with specific focus on Cagayan Valley Medical Center. A cross-sectional readiness diagnostic design was used to determine the preparedness of respiratory therapists across clinical assessment, technical and equipment handling, emergency response, interprofessional coordination, and continuing professional development. Purposive criterion sampling was employed, and data were gathered through a validated researcher-made questionnaire. The instrument underwent expert validation and pilot testing, producing an overall Cronbach's alpha of 0.94, which indicated excellent reliability. Data were analyzed using frequency percentage, median, interquartile range,

normalized Readiness Index, Domain Priority Score, and item-level readiness priority matrix. Results showed that respiratory therapists demonstrated high overall readiness for high-acuity patient management, with clinical assessment emerging as the strongest area. However, readiness was less consistent in emergency response, ventilator alarm troubleshooting, advanced respiratory equipment handling, patient transport during unstable conditions, simulation-based training, and post-event case review. These findings suggest that the respiratory therapy workforce was generally capable of managing complex respiratory cases, but selected areas required focused improvement to ensure more consistent performance in urgent and technically demanding situations. The study recommends regular competency-based training, airway emergency simulations, ventilator troubleshooting exercises, high-flow oxygen device handling sessions, structured handoff practice, and post-critical event debriefing. Strengthening these areas may help improve respiratory therapists' confidence, technical precision, and coordinated response in high-acuity care environments.

**Keywords:** *clinical readiness, emergency response, high-acuity care, respiratory therapists, ventilator management*

## INTRODUCTION

High-acuity patient management remains one of the most demanding areas of hospital care because it involves patients whose conditions may change rapidly and whose survival often depends on timely assessment, correct clinical judgment, and close monitoring of respiratory status. In intensive care units, emergency departments, operating rooms, and specialty care areas, respiratory compromise may progress from mild oxygen desaturation to acute respiratory failure within a short period. For this reason, hospital teams must be prepared to provide oxygen therapy, high-flow nasal oxygen, noninvasive ventilation, invasive mechanical ventilation, airway care, arterial blood gas interpretation, and continuous patient monitoring. Current clinical guidelines on acute respiratory distress syndrome and critical respiratory failure emphasize lung-protective ventilation, oxygenation

targets, close assessment for respiratory deterioration, and careful management of mechanically ventilated patients (Fan et al., 2017; Alhazzani et al., 2020). These standards show that respiratory care in high-acuity settings is not limited to operating equipment, but also requires readiness to make accurate bedside decisions under pressure.

Respiratory therapists are central members of the hospital team in the care of patients with severe respiratory illness. Their work often includes assessment of breathing patterns, oxygenation and ventilation support, ventilator set-up and adjustment, secretion management, emergency response, transport support, and collaboration with physicians and nurses in critical care decision-making. West et al. (2016) reported that respiratory therapist staffing and practice patterns in adult intensive care units are important areas of inquiry because they may influence both short-term and long-term patient outcomes. Similarly, Acho et al. (2022) emphasized the crucial role of respiratory therapists in managing mechanically ventilated patients, particularly in recognizing patient-ventilator asynchrony, which can contribute to patient harm if not detected and corrected promptly. These findings suggest that the readiness of respiratory therapists must be examined not only in terms of knowledge, but also in relation to actual clinical performance, confidence, teamwork, and response to complex patient conditions.

Readiness for high-acuity patient management requires more than routine familiarity with respiratory procedures. It involves the ability to recognize early signs of deterioration, prioritize interventions, communicate changes clearly, and adjust respiratory support based on patient response. The increasing use of high-flow nasal oxygen and other forms of advanced respiratory support has also widened the range of decisions that respiratory therapists encounter at the bedside. The American College of Physicians released evidence-based recommendations on the use of high-flow nasal oxygen for hospitalized adults with acute respiratory failure, noting its use in initial and post-extubation management (Qaseem et al., 2021). The European Respiratory Society also issued clinical practice guidelines on high-flow nasal cannula use in acute respiratory failure, reflecting the growing role of noninvasive respiratory support in modern hospital practice (Oczkowski et al., 2022). In this context, readiness becomes a practical concern because respiratory therapists must be able to match the correct intervention to the patient's condition while remaining alert to signs of treatment failure.

The need to examine readiness is also connected to workforce preparation and hospital capacity. The World Health Organization has emphasized that health systems depend on the availability, quality, training, deployment, and performance of health workers, especially in settings where workforce demands continue to increase (World Health Organization, 2026). This concern is highly relevant to respiratory therapy because high-acuity care depends on competent personnel who can respond safely to emergencies, technology-driven procedures, and interprofessional clinical decisions. Recent work on mechanical ventilation education further supports this need. Ramadurai et al. (2025) developed an interprofessional mechanical ventilation curriculum for critical care trainees, showing that mechanical ventilation is a core area where structured training can strengthen clinical readiness. For respiratory therapists, this points to the importance of continuous education, simulation, supervised practice, and institutional support in maintaining competence for high-risk patient care.

At Cagayan Valley Medical Center, the readiness of respiratory therapists is especially significant because the institution functions as a major referral hospital for Cagayan Valley and nearby provinces. The hospital identifies itself as a referral center serving the five provinces of Cagayan Valley, including nearby Apayao and Kalinga, and has stated its direction toward becoming a regional apex multispecialty center in Northeast Luzon (Cagayan Valley Medical Center, n.d.). Recent public reports also noted that CVMC has strengthened its pulmonary services through its Lung Care Center, which includes pulmonary function testing and a stated aim of providing advanced diagnostic services and care in Pulmonary Critical Care Medicine (Philippine Information Agency, 2024). These developments make respiratory therapy readiness a timely and meaningful subject for inquiry because improved pulmonary and critical care services must be supported by therapists who are clinically prepared, technically competent, and confident in managing high-acuity respiratory cases.

This study examines the preparedness of respiratory therapists in the specific setting of Cagayan Valley Medical Center. It is grounded on the understanding that readiness is reflected in clinical knowledge, technical skill, critical thinking, emergency response, communication, and collaboration within the hospital team. By

focusing on respiratory therapists in a regional referral and specialty care institution, the study may provide useful evidence on strengths, gaps, and support needs in high-acuity respiratory care. More importantly, it may contribute to patient safety, workforce development, and quality improvement by identifying how respiratory therapists can be better supported in caring for patients who require urgent, complex, and closely monitored respiratory management.

## **Literature Review**

### ***Clinical Competence in High-Acuity Respiratory Care***

Readiness in high-acuity respiratory care begins with strong clinical competence because respiratory therapists are expected to recognize deterioration, interpret oxygenation and ventilation needs, and respond quickly to changes in patient condition. In acute and critical care settings, oxygen therapy is not a simple routine task because inappropriate oxygen delivery may expose patients to avoidable risks. Piraino et al. (2022) emphasized that oxygen care in hospitalized adults should follow evidence-based targets, including appropriate monitoring, early consideration of high-flow oxygen, and humidification when clinically indicated. This is closely related to readiness because the respiratory therapist must judge when oxygen support is sufficient, when escalation is needed, and when the patient's response signals worsening respiratory failure. Goodfellow et al. (2024) likewise stressed the value of regular patient-ventilator assessment, including physical examination, airway evaluation, ventilator settings, humidification, documentation, and modifications in care. These sources show that clinical readiness is not limited to knowing procedures, but includes careful bedside assessment, disciplined monitoring, and the ability to translate patient findings into timely respiratory care decisions.

### ***Technical Readiness for Mechanical Ventilation and Ventilator Liberation***

Technical readiness is central to the work of respiratory therapists in high-acuity units because mechanically ventilated patients require precise monitoring, correct ventilator settings, and early recognition of complications. Berg et al. (2024) found that a respiratory therapist-driven mechanical ventilation protocol improved adherence to lung-protective ventilation guidelines and was associated with a lower incidence of acute respiratory distress syndrome in the post-intervention group. This finding supports the view that trained respiratory therapists can contribute meaningfully to safer ventilation practices when protocols are clear and supported by the institution. Roberts et al. (2024) also emphasized standardized assessment for spontaneous breathing trials and timely completion of trials for patients who may be ready for liberation from mechanical ventilation. In practice, this means that readiness includes the ability to assess ventilator tolerance, identify signs of readiness for weaning, protect patients from ventilator-associated harm, and coordinate with the critical care team before extubation decisions are made. For Cagayan Valley Medical Center, this area is important because high-acuity patient management often depends on whether respiratory therapists can combine technical skill with sound clinical timing.

### ***Interprofessional Communication and Team-Based Response***

High-acuity respiratory care is rarely performed by one professional alone, which makes interprofessional communication an important part of respiratory therapist readiness. Respiratory therapists work closely with physicians, nurses, and other members of the hospital team during airway emergencies, ventilator adjustments, patient transport, resuscitation, and post-extubation monitoring. Kleib et al. (2021) found that interprofessional simulation involving nursing and respiratory therapy students was useful in promoting teamwork and communication, which are necessary in complex healthcare settings. Dietl et al. (2023) further showed that communication training and psychological safety can support safer teamwork because health workers are more likely to raise concerns, clarify decisions, and act on patient safety risks when team communication is open and structured. In high-acuity respiratory care, this is especially important because delayed reporting of oxygen desaturation, unclear handoffs, or hesitation during ventilator-related concerns may place patients at risk. Thus,

readiness should include not only individual skill, but also the confidence and discipline to communicate clearly during urgent clinical situations.

### ***Continuing Education, Simulation, and Workforce Support***

The readiness of respiratory therapists must be maintained through continuing education, simulation-based learning, and a work environment that allows safe practice. Sreedharan et al. (2024) noted that simulation-based teaching and learning in respiratory care can improve clinical skills by allowing learners to practice decision-making and technical procedures in realistic but controlled situations. This is valuable for high-acuity care because some respiratory emergencies are high-risk but not always frequent enough to develop confidence through routine exposure alone. However, readiness is also affected by staffing, workload, and well-being. Miller et al. (2021) reported that burnout was common among respiratory therapists during the COVID-19 pandemic and was associated with inadequate staffing, inability to complete assigned work, and burnout climate, while positive leadership was protective. Saragosa et al. (2024) similarly described how respiratory therapists experienced increased workload, changing policies, distressing workplace situations, and the need for stronger leadership inclusion and mental health support. These studies suggest that readiness is both a personal and institutional concern because competence must be strengthened by training, staffing support, leadership, and a culture that protects the respiratory care workforce.

## **METHODS**

### **Research Design**

The study used a cross-sectional readiness diagnostic design. This design was considered appropriate because the study did not merely describe the preparedness of respiratory therapists, but examined readiness as a practical condition shaped by clinical judgment, technical capability, emergency response, interprofessional coordination, and institutional support. The design allowed the researcher to generate a readiness profile of respiratory therapists at a single point in time and identify areas that required strengthening for high-acuity patient management. It also supported the classification of readiness domains according to their relative strength and priority for improvement. This approach was selected because the nature of the study required an assessment model that was more focused on workplace preparedness and service capability rather than a simple descriptive survey.

### **Research Locale**

The study was conducted at Cagayan Valley Medical Center, a government hospital located in Tuguegarao City, Cagayan. The locale was selected because the hospital serves as a major referral facility for patients requiring specialized and critical care services in Region II and nearby areas. Its hospital setting made it suitable for examining the readiness of respiratory therapists in managing high-acuity patients, particularly those requiring oxygen support, airway care, mechanical ventilation, close respiratory monitoring, and coordinated clinical intervention. The study was situated in areas where respiratory therapists were directly involved in patient care, including critical care, emergency, pulmonary, and other units where patients with unstable respiratory conditions were managed.

### **Participants and Sampling Technique**

The participants of the study were respiratory therapists assigned at Cagayan Valley Medical Center who had direct involvement in respiratory care services. They were selected because their duties placed them in situations where readiness for high-acuity patient management was necessary. The study included respiratory therapists who were actively rendering clinical service during the period of data gathering and who were willing to participate after being informed of the purpose and procedure of the study.

The study used purposive criterion sampling. This sampling technique was appropriate because the study required participants who had actual exposure to respiratory care procedures and hospital-based patient

management rather than respondents selected only by availability. The criteria helped ensure that the responses came from personnel whose work experience was relevant to the focus of the study. Respiratory therapists who were not assigned to clinical respiratory care duties during the data gathering period were not included.

### **Research Instrument**

The study used a researcher-made questionnaire developed from the objectives of the study and from the major competencies required in high-acuity respiratory care. The instrument was organized into key readiness domains, namely clinical assessment readiness, technical and equipment readiness, emergency response readiness, interprofessional coordination readiness, and continuing professional development readiness. Each item was written as a clear statement that could be answered using a five-point Likert scale.

The questionnaire underwent content validation before it was administered. A panel of validators composed of professionals with background in respiratory care, critical care practice, research, and health service management reviewed the instrument. They examined the clarity of each item, the relevance of the statements to the study objectives, the appropriateness of the language, and the completeness of the readiness domains. Their comments were used to revise vague, overlapping, or repetitive items. After revision, the instrument was found suitable for use in the study. The content validity review produced a satisfactory item-level and scale-level evaluation, indicating that the questionnaire adequately represented the areas of readiness being measured.

A pilot test was conducted among respiratory therapy personnel from a comparable hospital setting who were not included in the actual study. The pilot testing was done to determine whether the items were understandable, whether the directions were clear, and whether the response scale was easy to use. The pilot test also provided the basis for reliability analysis. The computed Cronbach's alpha for the entire instrument was 0.94, which indicated excellent internal consistency. The reliability coefficients of the readiness domains were also acceptable to excellent, with clinical assessment readiness obtaining 0.91, technical and equipment readiness obtaining 0.90, emergency response readiness obtaining 0.92, interprofessional coordination readiness obtaining 0.88, and continuing professional development readiness obtaining 0.89. These results showed that the instrument was reliable for measuring the readiness of respiratory therapists for high-acuity patient management.

### **Data Gathering**

The researcher first secured permission from the proper hospital authority before the conduct of the study. After approval was granted, coordination was made with the concerned office or unit to determine the appropriate schedule for questionnaire distribution without disrupting hospital operations. The purpose of the study, the voluntary nature of participation, and the confidentiality of responses were explained to the participants.

The questionnaires were distributed to the qualified participants during the approved data gathering period. The respondents were given enough time to read the instructions and answer the items honestly based on their actual experiences and perceptions. Completed questionnaires were retrieved, checked for completeness, and encoded for statistical analysis. Responses with incomplete major sections were not included in the final encoding to protect the accuracy of the data set. The collected data were then organized according to the readiness domains identified in the instrument.

### **Data Analysis**

The study used a readiness index approach supported by ordinal data analysis. Since the responses were obtained through a Likert scale, the data were treated carefully as ordered responses rather than as purely interval values. Frequency distribution and percentage were used to summarize the pattern of responses for each item. Median and interquartile range were used to describe the central tendency and spread of responses because these measures were more appropriate for ordinal data and were less affected by extreme ratings.

To determine the level of readiness in each domain, a normalized Readiness Index was computed. The index converted the obtained scores into a comparable readiness score for each domain, which allowed the researcher to identify the strongest and weakest areas of preparedness. The following readiness interpretation was used: very high readiness, high readiness, moderate readiness, low readiness, and very low readiness. A domain

priority score was also computed by combining the readiness index and response variability. This helped identify areas that needed attention not only because of lower readiness, but also because of inconsistent responses among participants.

For item-level analysis, a readiness priority matrix was used. Items with lower readiness index values and higher variability were treated as priority concerns for training, supervision, or institutional support. This method was selected because it provided a more useful basis for action planning than relying only on overall averages. The statistical analysis therefore focused on identifying practical readiness gaps that could guide hospital-based improvement measures for respiratory therapy practice in high-acuity care.

### **Ethical Consideration**

The study followed ethical standards in the conduct of research involving human participants. Permission was secured from the appropriate hospital authority before the data gathering activities were conducted. The participants were informed about the purpose of the study, the nature of their involvement, and their right to decline or withdraw without penalty. Participation was voluntary, and no respondent was forced to answer the questionnaire.

Confidentiality was strictly observed throughout the study. The names of the participants were not required in the questionnaire, and the responses were used only for research purposes. Data were handled with care and were reported in summarized form to prevent the identification of individual participants. The study also avoided any procedure that could interfere with patient care, hospital operations, or the professional duties of the respiratory therapists. The researcher ensured that the study remained respectful, non-disruptive, and aligned with the principles of informed consent, privacy, honesty, and professional responsibility.

## **RESULTS AND DISCUSSION**

Table 1. *Overall Readiness Classification of Respiratory Therapists for High-Acuity Patient Management*

Readiness Classification	Percentage
Very High Readiness	15.8
High Readiness	50.0
Moderate Readiness	30.3
Low Readiness	3.9
Very Low Readiness	0.0
Overall Median	4.00
Overall Interquartile Range	1.00
Overall Readiness Index	78.30
Overall Interpretation	High Readiness

The overall result showed that the respiratory therapists at Cagayan Valley Medical Center demonstrated high readiness for high-acuity patient management. The overall median of 4.00 indicated that the typical response leaned toward agreement with the readiness statements, while the interquartile range of 1.00 suggested that most responses were clustered within a relatively narrow range. This means that readiness was generally consistent, although not yet at a very high level across all areas. The distribution also showed that a large portion of the respondents fell under high readiness, while a considerable group remained at the moderate level. This finding suggests that the respiratory therapists were generally prepared to handle patients with unstable respiratory conditions, but some areas still needed strengthening. The presence of a small percentage under low readiness also indicated that readiness was not uniform among all therapists, which may be linked to differences in clinical exposure, training experience, confidence in emergency situations, or familiarity with advanced respiratory

equipment. Overall, the result reflected a capable respiratory therapy workforce, but one that still required focused support to achieve more consistent high-acuity performance.

Table 2. *Readiness Profile of Respiratory Therapists by Domain*

Readiness Domain	Median	IQR	Readiness Index	Interpretation	Domain Priority Score	Priority Rank
Clinical Assessment Readiness	4.00	1.00	83.20	High Readiness	21.80	5
Technical and Equipment Readiness	4.00	2.00	76.50	High Readiness	33.50	2
Emergency Response Readiness	4.00	2.00	72.80	High Readiness	37.20	1
Interprofessional Coordination Readiness	4.00	1.00	80.60	High Readiness	24.40	4
Continuing Professional Development Readiness	4.00	1.00	78.10	High Readiness	26.90	3
Overall	4.00	1.00	78.24	High Readiness		

The domain results showed that all five readiness areas were interpreted as high readiness, but the readiness index and priority scores revealed important differences. Clinical assessment readiness obtained the highest readiness index, which means that the respiratory therapists were most confident in recognizing respiratory status, observing patient changes, and assessing common clinical signs related to breathing difficulty, oxygenation, and ventilation needs. This was a positive result because accurate assessment is the starting point of safe high-acuity care.

However, the highest priority score appeared in emergency response readiness, followed by technical and equipment readiness. This means that although the therapists rated themselves as generally ready, these two areas showed lower readiness index values and wider response variation. The interquartile range of 2.00 in these domains suggested that readiness was not evenly experienced by all respondents. Some therapists may have felt highly prepared, while others may have had only moderate confidence in responding to sudden desaturation, airway emergencies, ventilator alarms, or unstable patient transfers. This was a meaningful finding because high-acuity patient care often requires quick action under pressure. The result implies that the hospital may benefit from stronger emergency drills, clearer response protocols, and more frequent hands-on training with critical care equipment.

Interprofessional coordination readiness also registered a high readiness index, showing that respiratory therapists were generally able to communicate and coordinate with nurses, physicians, and other health personnel. Still, its priority score indicated room for improvement, especially in structured handoffs and post-event communication. Continuing professional development readiness also needed attention because high-acuity care changes with new equipment, updated protocols, and evolving standards in respiratory support. Taken together, the findings suggested that the respiratory therapists were prepared, but their readiness was stronger in routine clinical assessment than in high-pressure and equipment-intensive situations.

Table 3. *Percentage Distribution of Responses by Readiness Domain*

Readiness Domain	Strongly Agree	Agree	Moderately Agree	Disagree	Strongly Disagree
Clinical Assessment Readiness	28.60	50.40	18.80	2.20	0.00
Technical and Equipment Readiness	22.10	45.70	27.90	4.30	0.00
Emergency Response Readiness	18.50	46.20	29.40	5.90	0.00

Readiness Domain	Strongly Agree	Agree	Moderately Agree	Disagree	Strongly Disagree
Interprofessional Coordination Readiness	25.30	49.10	23.40	2.20	0.00
Continuing Professional Development Readiness	20.90	48.60	26.30	4.20	0.00

The response distribution supported the overall interpretation that readiness was high but still uneven. Clinical assessment readiness had the largest combined percentage of strongly agree and agree responses, which confirmed that the respiratory therapists were most prepared in identifying patient needs, monitoring respiratory changes, and recognizing signs that required further intervention. This showed that bedside assessment was a relative strength of the group.

Emergency response readiness had the lowest percentage of strongly agree responses and the highest percentage of disagreement. Although the disagreement remained small, it was still important because emergency response is a critical area in high-acuity care. Even a small group of therapists who felt less ready could affect the consistency of service delivery during urgent situations. Technical and equipment readiness showed a similar pattern, with a notable percentage of moderately agree responses. This suggested that some therapists could perform standard equipment-related procedures but may still need more confidence in troubleshooting, using advanced modes, or responding to equipment-related concerns during unstable patient conditions.

The results for interprofessional coordination and continuing professional development were generally favorable, but both domains had a sizable portion of moderately agree responses. This means that while coordination and learning activities were present, they may not have been consistently strong across all situations. The findings showed that the readiness problem was not a lack of general capability. Rather, the concern was the need to move therapists from moderate confidence to stronger, more consistent readiness in the most demanding areas of high-acuity care.

Table 4. *Item-Level Readiness Priority Matrix*

Readiness Item	Median	IQR	Readiness Index	Priority Level
I recognized early signs of respiratory deterioration based on patient assessment findings.	4.00	1.00	84.10	Low Priority
I interpreted changes in oxygen saturation, breathing pattern, and patient effort during monitoring.	4.00	1.00	83.60	Low Priority
I adjusted oxygen therapy based on patient response and prescribed oxygenation goals.	4.00	1.00	82.40	Low Priority
I prepared and checked respiratory equipment before use in high-acuity patient care.	4.00	1.00	80.20	Moderate Priority
I operated high-flow oxygen devices with confidence during acute respiratory support.	4.00	2.00	75.90	High Priority
I checked ventilator settings, alarms, humidification, and circuit condition during patient care.	4.00	1.00	79.40	Moderate Priority
I responded promptly to ventilator alarms and identified possible causes during unstable patient episodes.	4.00	2.00	71.80	High Priority
I assisted effectively during emergency airway management and intubation-related procedures.	4.00	2.00	73.60	High Priority
I managed sudden oxygen desaturation during patient transport, procedures, or unit transfer.	4.00	2.00	70.40	High Priority
I communicated urgent respiratory changes clearly to physicians and nurses.	4.00	1.00	80.10	Moderate Priority

Readiness Item	Median	IQR	Readiness Index	Priority Level
I participated in team debriefing or case review after critical respiratory events.	3.00	2.00	69.20	High Priority
I received sufficient simulation-based training for airway emergencies and mechanical ventilation concerns.	3.00	2.00	66.80	Very High Priority
I had regular access to updated protocols or refresher sessions on high-acuity respiratory care.	4.00	2.00	72.10	High Priority
I felt supported by the institution in maintaining competence for high-risk respiratory procedures.	4.00	1.00	76.60	Moderate Priority

The item-level matrix provided a clearer view of where readiness was strong and where improvement was needed. The strongest items were related to recognizing respiratory deterioration, interpreting oxygenation changes, and adjusting oxygen therapy based on patient response. These results suggested that respiratory therapists had a solid foundation in patient observation and bedside clinical assessment. This was an important strength because high-acuity care begins with noticing small but meaningful changes in the patient's condition.

The items with higher priority levels were mostly connected to emergency action, ventilator troubleshooting, advanced oxygen support, simulation training, and participation in post-event review. The lowest readiness index was recorded in simulation-based training for airway emergencies and mechanical ventilation concerns. This result suggested that the therapists may not have received enough structured opportunities to practice rare but high-risk situations in a safe and controlled setting. This is a realistic concern in hospital practice because actual emergencies require immediate action, but learning during real emergencies may be limited by pressure, patient risk, and unit workload.

The item on managing sudden oxygen desaturation during transport or procedures also required attention. Patient movement between units or diagnostic areas can increase risk, especially when the patient is dependent on oxygen support, ventilatory assistance, or close monitoring. The high priority rating for this item showed the need for clearer transport preparation, equipment checks, and role assignment before moving high-acuity patients. Ventilator alarm response also appeared as a high-priority area, indicating the need for more focused training on alarm interpretation, circuit problems, patient-ventilator mismatch, and immediate corrective actions. These findings showed that readiness was present, but it was less secure in situations that required fast judgment and hands-on troubleshooting.

Table 5. *Readiness Priority Classification by Domain*

Domain	Readiness Status	Variability Pattern	Priority Classification	Recommended Focus
Clinical Assessment Readiness	High	Narrow variability	Sustain	Maintain assessment standards and reinforce routine bedside monitoring practices.
Technical and Equipment Readiness	High	Wide variability	Strengthen Immediately	Improve equipment drills, ventilator checks, alarm response, and high-flow oxygen device handling.
Emergency Response Readiness	High	Wide variability	Highest Improvement Priority	Conduct repeated emergency simulations, airway response drills, and desaturation management exercises.
Interprofessional Coordination Readiness	High	Narrow variability	Strengthen Selectively	Improve structured handoff, escalation reporting, and post-event communication.
Continuing Professional Development Readiness	High	Moderate variability	Strengthen Continuously	Provide regular refresher sessions, protocol updates, and competency-based training.

The priority classification showed that the main concern of the study was not the absence of readiness, but the uneven strength of readiness across domains. Clinical assessment readiness was classified as a domain to sustain because it had a high readiness index and narrow variability. This means that the therapists generally shared a dependable level of preparedness in assessing patients and observing respiratory changes.

Emergency response readiness was identified as the highest improvement priority because it had the lowest readiness index and wider variability. This finding was significant because high-acuity patient management often depends on how well respiratory therapists respond during sudden deterioration. A therapist may be clinically knowledgeable, but emergency readiness requires quick movement, clear prioritization, calm communication, and familiarity with equipment under pressure. The same issue was observed in technical and equipment readiness. Although the overall rating was high, the wider variability suggested that not all therapists had the same level of confidence in using and troubleshooting advanced respiratory equipment.

The results also showed that interprofessional coordination and continuing professional development should not be overlooked. Coordination was already favorable, but selected improvements were still needed in structured communication and case review. Continuing professional development required sustained attention because readiness cannot remain strong without regular updating, especially in a hospital setting where respiratory care technologies and procedures continue to develop. These findings support the need for a readiness improvement plan focused on emergency simulation, technical competency checks, structured communication, and continuous learning.

Table 6. *Summary of Targeted Results Based on the Readiness Diagnostic Analysis*

Targeted Area	Main Result	Interpretation
Overall readiness for high-acuity patient management	Readiness Index of 78.30	Respiratory therapists had high readiness, but readiness was not yet consistently very high.
Strongest readiness domain	Clinical Assessment Readiness	Therapists were most prepared in recognizing respiratory changes and assessing patient condition.
Lowest readiness domain	Emergency Response Readiness	Urgent care situations showed the greatest need for improvement.
Most variable domain	Emergency Response Readiness and Technical and Equipment Readiness	Responses differed more widely in high-pressure and equipment-related tasks.
Highest item priority	Simulation-based training for airway emergencies and mechanical ventilation concerns	More structured practice was needed for rare but high-risk events.
Most important institutional need	Competency-based training and emergency drills	Readiness could be strengthened through regular skills validation, protocol review, and simulation.
Overall readiness problem	Uneven preparedness across high-acuity situations	The workforce was capable, but readiness gaps remained in emergency response, equipment troubleshooting, and continuing training.

The summary of targeted results showed that respiratory therapists at Cagayan Valley Medical Center were generally ready for high-acuity patient management, but the readiness profile was not without concern. The strongest area was clinical assessment, which indicated that the therapists were able to observe, interpret, and respond to patient signs in routine and closely monitored settings. This was an encouraging result because assessment is the foundation of respiratory care.

However, the results also identified a practical problem. The readiness of respiratory therapists became less consistent when the task involved emergency response, advanced equipment handling, ventilator troubleshooting, and simulation-based preparation. These are the exact areas where high-acuity patient management becomes most demanding. The findings suggested that the therapists could manage many aspects of

care, but some may require additional support when situations become urgent, unpredictable, or technically complex.

The most important implication of the findings is the need for a structured readiness improvement program. Such a program should not be limited to lectures or written protocols. It should include actual hands-on drills, simulation of sudden desaturation and airway emergencies, ventilator alarm troubleshooting, high-flow oxygen device handling, patient transport preparation, structured handoff practice, and post-event debriefing. These activities may help reduce variability in readiness and build a more uniform level of confidence among respiratory therapists. Overall, the study showed that the hospital had a capable respiratory therapy workforce, but readiness for high-acuity care could still be strengthened through targeted, repeated, and competency-based institutional support.

## CONCLUSION

Respiratory therapists at Cagayan Valley Medical Center demonstrated high overall readiness for high-acuity patient management, particularly in clinical assessment, recognition of respiratory deterioration, oxygenation monitoring, and routine bedside respiratory care; however, readiness was not yet consistently very high across all domains, as gaps remained in emergency response, advanced equipment handling, ventilator alarm troubleshooting, patient transport during unstable conditions, simulation-based training, and post-event case review. These findings indicate that the respiratory therapy workforce was generally capable of managing patients with complex respiratory needs, but preparedness became less consistent when care situations required rapid decision-making, technical precision, and coordinated action under pressure. Based on these conclusions, it is recommended that the hospital strengthen competency-based training for respiratory therapists through regular emergency drills, airway management simulations, ventilator troubleshooting exercises, high-flow oxygen device handling sessions, and structured patient transport protocols. It is also recommended that respiratory care units adopt scheduled skills validation, updated clinical protocol reviews, interprofessional handoff practice, and post-critical event debriefing to improve communication, confidence, and consistency in high-acuity care. Hospital administrators should further support respiratory therapists by ensuring access to updated equipment, refresher training, mentoring, and continuing professional development opportunities. Future researchers may expand the study by including other hospitals, comparing readiness across clinical units, or examining how respiratory therapist readiness influences patient safety indicators and high-acuity care outcomes.

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