

CHAPTER 722
PRACTICE OF RESPIRATORY CARE PRACTITIONERS AND
POLYSOMNOGRAPHIC TECHNOLOGISTS

[Prior to 9/18/24, see Professional Licensure Division[645] Ch 265]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/31/29

481—722.1(148G,152B,272C) Definitions.

“Board” means the board of respiratory care and polysomnography.

“Direct supervision” means that the respiratory care and polysomnography practitioner or the polysomnographic technologist providing supervision must be present where the polysomnographic procedure is being performed and immediately available to furnish assistance and direction throughout the performance of the procedure.

“General supervision” means that the polysomnographic procedure is provided under a physician’s or qualified health care professional prescriber’s overall direction and control, but the physician’s or qualified health care professional prescriber’s presence is not required during the performance of the procedure.

“Physician” means a person who is currently licensed in Iowa to practice medicine and surgery or osteopathic medicine and surgery, is board-certified, and is actively involved in the sleep medicine center or laboratory.

“Polysomnographic student” means a person who is enrolled in a program approved by the board and who may provide sleep-related services under the direct supervision of a respiratory care and polysomnography practitioner or a polysomnographic technologist as part of the person’s education program.

“Polysomnographic technician” means a person who has graduated from a program approved by the board, but has not yet received an accepted national credential awarded from an examination program approved by the board and who may provide sleep-related services under the direct supervision of a licensed respiratory care and polysomnography practitioner or a licensed polysomnographic technologist for a period of up to 30 days following graduation while awaiting credentialing examination scheduling and results.

[ARC 8076C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—722.2(148G,152B,272C) Code of ethics.

722.2(1) The respiratory care practitioner or polysomnographic technologist will practice acceptable methods of treatment and will not practice beyond the competence or exceed the authority vested in the practitioner or technologist by physicians.

722.2(2) The respiratory care practitioner or polysomnographic technologist will continually strive to increase and improve knowledge and skill and will render to each patient the full measure of the practitioner’s or technologist’s ability. All services will be provided with respect for the dignity of the patient, regardless of the patient’s social or economic status or personal attributes or the nature of the patient’s health problems.

722.2(3) The respiratory care practitioner or polysomnographic technologist will be responsible for the competent and efficient performance of assigned duties and will expose incompetent, illegal or unethical conduct of members of the profession.

722.2(4) The respiratory care practitioner or polysomnographic technologist will hold in confidence all privileged information concerning the patient and refer all inquiries regarding the patient to the patient’s physician.

722.2(5) The respiratory care practitioner or polysomnographic technologist will not accept gratuities and shall guard against conflict of interest.

722.2(6) The respiratory care practitioner or polysomnographic technologist will uphold the dignity and honor of the profession and abide by its ethical principles.

722.2(7) The respiratory care practitioner or polysomnographic technologist will have knowledge of existing state and federal laws governing the practice of respiratory therapy or polysomnography and will comply with those laws.

722.2(8) The respiratory care practitioner or polysomnographic technologist will cooperate with other health care professionals and participate in activities to promote community, state, and national efforts to meet the health needs of the public.

[ARC 8076C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—722.3(152B,272C) Intravenous administration. Starting an intravenous line or administering intravenous medications is outside the scope of practice of a licensed respiratory care practitioner. However, this rule does not preclude a licensed respiratory care practitioner from performing intravenous administration under the auspices of the employing agency if formal training is acquired and documented.

[ARC 8076C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—722.4(152B,272C) Setup and delivery of respiratory care equipment.

722.4(1) Unlicensed personnel may deliver, set up, and test the operation of respiratory care equipment for a patient but will not perform any type of patient care. Instruction or demonstration of the equipment will be limited to its mechanical operation (on and off switches, emergency button, cleaning, maintenance). Any instruction or demonstration to the patient regarding the clinical use of the equipment; the fitting of any device to the patient or making any adjustment; or any patient monitoring, patient assessment, or other procedures designed to evaluate the effectiveness of the treatment must be performed by a licensed respiratory therapist or other licensed health care provider allowed by Iowa law.

722.4(2) Respiratory care equipment includes but is not limited to:

- a. Positive airway pressure (continuous positive airway pressure and bi-level positive airway pressure) devices and supplies;
- b. Airway clearance devices;
- c. Invasive and noninvasive mechanical ventilation devices and supplies;
- d. Nasotracheal and tracheal suctioning devices and supplies;
- e. Apnea monitors and alarms and supplies;
- f. Tracheostomy care devices and supplies;
- g. Respiratory diagnostic testing devices and supplies, including but not limited to pulse oximetry, CO₂ monitoring, and spirometry devices and supplies; and
- h. Pulse-dose or demand-type oxygen conserving devices or any oxygen delivery systems beyond the capabilities of a simple mask or cannula or requiring particulate or molecular therapy in conjunction with oxygen.

[ARC 8076C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—722.5(152B,272C) Respiratory care as a practice. “Respiratory care as a practice” means a health care profession, under medical direction, employed in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities that affect the pulmonary system and associated aspects of cardiopulmonary and other systems’ functions and includes but is not limited to the following direct and indirect respiratory care services that are safe, of comfort, aseptic, preventative, and restorative to the patient:

1. Observing and monitoring signs and symptoms, general behavior, reactions, and general physical responses to respiratory care treatment and diagnostic testing.
2. Determining whether the signs, symptoms, behavior, reactions, or general responses exhibit abnormal characteristics.
3. Performing pulmonary diagnostic testing.
4. Analyzing blood gases and respiratory secretions.
5. Measuring and monitoring hemodynamic and physiologic function related to cardiopulmonary pathophysiology.
6. Performing diagnostic and testing techniques in the medical management of patients to assist in diagnosis, monitoring, treatment, and research of pulmonary abnormalities, including measurement of

ventilatory volumes, pressures, and flows; and collection of specimens of blood and from the respiratory tract.

7. Administering:
 - Medical gases, aerosols, and humidification, not including general anesthesia.
 - Lung expansion therapies.
 - Bronchopulmonary hygiene therapies.
 - Hyperbaric therapy.
 - Pharmacologic and therapeutic agents necessary to implement therapeutic, disease prevention, pulmonary rehabilitative, or diagnostic regimens prescribed by a licensed physician, surgeon, or other qualified health care professional prescriber.
 8. Maintaining natural and artificial airways.
 9. Without cutting tissues, inserting and maintaining artificial airways.
 10. Initiating, monitoring, modifying and discontinuing invasive or noninvasive mechanical ventilation.
 11. Performing basic and advanced cardiopulmonary resuscitation.
 12. Performing invasive procedures that relate to respiratory care.
 13. Implementing changes in treatment regimen based on observed abnormalities and respiratory care protocols to include appropriate reporting and referral.
 14. Managing asthma, COPD, and other respiratory diseases.
 15. Performing cardiopulmonary rehabilitation.
 16. Instructing patients in respiratory care, functional training in self-care and home respiratory care management and promoting the maintenance of respiratory care fitness, health, and quality of life.
 17. Performing those advanced practice procedures that are permitted within the policies of the employing institution and for which the respiratory care practitioner has documented training and demonstrated competence.
 18. Managing the clinical delivery of respiratory care services through the ongoing supervision, teaching, and evaluation of respiratory care.
 19. Transcribing and implementing a written, verbal, or telephonic order from a licensed physician, surgeon, or other qualified health care professional prescriber pertaining to the practice of respiratory care.
- [ARC 8076C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—722.6(148G,272C) Practice of polysomnography.

722.6(1) The practice of polysomnography consists of but is not limited to the following tasks as performed for the purpose of polysomnography, under the general supervision of a licensed physician or qualified health care professional prescriber:

- a. Monitoring, recording, and evaluating physiologic data during polysomnographic testing and review during the evaluation of sleep-related disorders, including sleep-related respiratory disturbances, by applying any of the following techniques, equipment, or procedures:
 - (1) Noninvasive continuous, bilevel positive airway pressure, or adaptive servo-ventilation titration on spontaneously breathing patients using a mask or oral appliance; provided, however, that the mask or oral appliance does not extend into the trachea or attach to an artificial airway.
 - (2) Supplemental low-flow oxygen therapy of less than six liters per minute, utilizing a nasal cannula or incorporated into a positive airway pressure device during a polysomnogram.
 - (3) Capnography during a polysomnogram.
 - (4) Cardiopulmonary resuscitation.
 - (5) Pulse oximetry.
 - (6) Gastroesophageal pH monitoring.
 - (7) Esophageal pressure monitoring.
 - (8) Sleep stage recording using surface electroencephalography, surface electrooculography, and surface submental electromyography.
 - (9) Surface electromyography.
 - (10) Electrocardiography.
 - (11) Respiratory effort monitoring, including thoracic and abdominal movement.

- (12) Plethysmography blood flow monitoring.
- (13) Snore monitoring.
- (14) Audio and video monitoring.
- (15) Body movement monitoring.
- (16) Nocturnal penile tumescence monitoring.
- (17) Nasal and oral airflow monitoring.
- (18) Body temperature monitoring.

b. Monitoring the effects that a mask or oral appliance used to treat sleep disorders has on sleep patterns; provided, however, that the mask or oral appliance does not extend into the trachea or attach to an artificial airway.

c. Observing and monitoring physical signs and symptoms, general behavior, and general physical response to polysomnographic evaluation and determining whether initiation, modification, or discontinuation of a treatment regimen is warranted.

d. Analyzing and scoring data collected during the monitoring described in this subrule for the purpose of assisting a physician in the diagnosis and treatment of sleep and wake disorders that result from developmental defects, the aging process, physical injury, disease, or actual or anticipated somatic dysfunction.

e. Implementation of a written or verbal order from a physician or qualified health care professional prescriber to perform polysomnography.

f. Education of a patient regarding the treatment regimen that assists the patient in improving the patient's sleep.

g. Use of any oral appliance used to treat sleep-disordered breathing while under the care of a licensed polysomnographic technologist during the performance of a sleep study, as directed by a licensed dentist.

722.6(2) Before providing any sleep-related services, a polysomnographic technician or polysomnographic student who is obtaining clinical experience will give notice to the board that the person is working under the direct supervision of a respiratory care and polysomnography practitioner or a polysomnographic technologist in order to gain the experience to be eligible to sit for a national certification examination. A badge that appropriately identifies the person is to be worn while providing such services.

[ARC 8076C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—722.7(148G,152B,272C) Students.

722.7(1) A student who is enrolled in an approved respiratory care, sleep add-on, polysomnography training program, or electroneurodiagnostic program and is employed in an organized health care system may render services defined in Iowa Code sections 152B.2 and 152B.3 and chapter 148G under the direct and immediate supervision of a respiratory care practitioner, polysomnographic technologist, or respiratory care and polysomnography practitioner for the duration of the program, but not to exceed the duration of the program.

722.7(2) Direct and immediate supervision of a respiratory care or polysomnographic student means that the licensed respiratory care practitioner or polysomnographic technologist will:

- a.* Be continuously on site and present in the department or facility where the student is performing care;
- b.* Be immediately available to assist the person being supervised in the care being performed; and
- c.* Be responsible for care provided by students.

[ARC 8076C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—722.8(148G,272C) Location of polysomnography services. The practice of polysomnography is to take place only in a facility that is accredited by a nationally recognized sleep medicine laboratory or center accrediting agency, in a facility operated by a hospital or a hospital licensed under Iowa Code chapter 135B, or in a patient's home pursuant to rules adopted by the board; provided, however, that the scoring of data and the education of patients may take place in another setting.

[ARC 8076C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

These rules are intended to implement Iowa Code chapters 147, 148G, 152B, and 272C.

[Filed 9/26/02, Notice 5/29/02—published 10/16/02, effective 11/20/02]

[Filed 7/23/07, Notice 5/23/07—published 8/15/07, effective 9/19/07]

[Filed ARC 0537C (Notice ARC 0221C, IAB 7/25/12), IAB 12/26/12, effective 1/30/13]

[Filed ARC 1453C (Notice ARC 1255C, IAB 12/25/13), IAB 5/14/14, effective 6/18/14]

[Filed ARC 2323C (Notice ARC 2224C, IAB 10/28/15), IAB 12/23/15, effective 1/27/16]

[Filed ARC 8076C (Notice ARC 7506C, IAB 1/24/24), IAB 6/26/24, effective 7/31/24]

[Editorial change: IAC Supplement 9/18/24]