VOLUME 20, NO. 1 ◆ 2012 SPRING ISSUE

the exchange

The Newsletter of the College of Respiratory Therapists of Ontario

INSIDE:

Your fellow RTs

...hard at work helping you!

The CRTO would like to thank the following **QA Working Group** Members for the valuable assistance they have provided the College over the past few months. We are very grateful for the contribution to the CRTO QA Program that the professional insight of these RT Members provide.

QA Portfolio Reviewers are RTs who volunteered and receive yearly training in the assessment of PORTfolios. These assessments are completed and submitted electronically by the Reviewers and therefore can be done by them at home when their busy schedules permit.

- **Tracy Bonifacio**
- **Gary Cambridge**
- **Cathy Dowsett**
- **Lori Elder**
- **Anne Marie Hayes**
- **Jane Heath**
- **Jeff Hunter**
- **Glynis Kirtz**
- **Amanda Lajoie**
- **Vanessa Lamarche**
- **Lise LaRose**
- **Shawna MacDonald**
- **Jackie Parent**
- **Patti Redpath-Platter**
- **Kathy Walker**
- **Jane Wheildon**
- **Karen Weins**

QA Item Reviewers are RTs who participate in the yearly review of the Professional Standards Assessment (PSA) which involves examining the performance of each test item, as well as comments from Members. This is done with the services of psychometrician, Michael Williams.

- **Eric Cheng**
- **Katie Lalonde**
- **Rosanne Leddy**
- **Christina Sperling**
- **Andrea White-Markham**

QA Item Writers are RTs who participate in a group that works in conjunction with the psychometrician to develop and revise questions for the PSA item bank.

- **Michael Kampen**
- **Laurie Mendoza**
- **Lindsay McClelland**
- **Doug Patterson**
- **Patti Redpath-Platter**
- **Dale Schwartz**

* If you are interested in participating in any one of these roles please contact Carole Hamp.

Respiratory Health Information Cards

The CRTO has produced "business cards" displaying a Quick Response (QR) code that will connect you or your patients/clients to the College's Respiratory Health Information page at www.crto.on.ca/RespHealth.aspx.

Giving your patients/clients a card will provide them with a link to information on a variety of respiratory health topics such as asthma, COPD and sleep apnea. The card can be used by entering the web address in an Internet browser or by using a smart phone, with a QR reader installed, to scan the pixilated code for instant access to the respiratory health page. In addition, it is anticipated that members of the public who utilize this link may also learn more about the profession of Respiratory Therapy and the important role that RTs play in the healthcare system.

If you would like to receive some of these cards for use in your practice, please contact Carole Hamp RRT, Manager of Quality Assurance & Member Relations at hamp@crto.on.ca.

Adult Tracheostomy Care Team at The Credit Valley Hospital and Trillium Health Centre (Credit Valley Site)

By Cynthia Welton, RRT, Hon BSc, FCSRT

There are a significant number of our Critical Care Unit (CCU) patients who require percutaneous tracheostomies and these are most often inserted at the bedside by a general or thoracic surgeon. The RT staff were concerned that when these patients were subsequently discharged from the CCU, there was often no Most Responsible Physician (MRP) available to take responsibility for the management of their trach on an ongoing basis. It was then up to the RT to advocate for the individual patient and obtain orders for each procedure we needed to do (e.g., deflating the cuff, first trach change, etc.). There was also a hospital policy that outlined that the physician would do the first trach change but not until one month after insertion. This meant that many patients went a long time without an initial trach change, which in turn delayed the downsizing process. Ear Nose and Throat (ENT) physician support was also needed for difficult trach changes or for requests to change to a different type of trach.

The Rapid Assessment of Critical Events (RACE) team at Credit Valley Hospital (CVH) follows all patients discharged from Critical Care for the first 48 hours. These follow-ups enable the RTs to obtain additional support and orders for trach patients from the RACE team physician, however after 48 hours the RACE team physician would no longer manage the trach. It was through the RACE team follow-up process that the idea for the Adult Tracheostomy Care Team was conceived. A working group consisting of the Professional Practice Lead (PPL) for RT, the RT Manager, a Speech and Language Pathologist (S-LP) and our Medical Director for Critical Care was established to create the model and documents for the trach team. Support for the development of the team was also received from the Nursing PPL and the Quality Safety & Risk department.

The Adult Tracheostomy Care Team working group obtained a *Low Risk Decannulation Pathway* that was developed by the Alberta Health

Back row: Cynthia Welton, Dr. Janos Pataki-Medical Director Critical Care Unit, Manjot Sanghera RRT, Juliana Chris S-LP
Front row: Janet Dukaczewski-Patient

Services and used this as a model for the team's processes. In addition, Trillium Health Center's tracheostomy protocols and an article from McGill University Health Centre *(Can J Surg, Vol 54, No 3, June 2011)* were used as reference material. CVH developed a set of Pre-Printed Orders (PPO) for weaning and decannulation that enabled the RT to perform the first trach change after 10 days, deflate the cuff, and initiate corking, etc., via a weaning algorithm. This enabled the RT to decannulate the patient following communication with the RACE team physician. Orders for S-LP referral for communication & swallowing assessment that are part of the PPO allowed for more timely referral and intervention. An interprofessional Policy and Procedure (P&P) was developed for ongoing trach care. This P&P applies to nurses, RTs and S-LPs and addresses routine daily trach care, trach changes, weaning, decannulation, and swallowing assessments.

The resulting Adult Tracheostomy Care Team consists of the RACE team physician, RT and S-LP. The team began meeting weekly in October 2011 to discuss all patients on the in-patient wards with a trach, including our patients that have had a trach for many years. To roll out the Adult Tracheostomy Care Team concept, we advertised throughout the hospital with posters, electronic messages and visits to the patient care units. We also provided reviews on trach care at global nursing skills days. The Adult Tracheostomy Care

Adult Tracheostomy Care Team *(continued)*

Team has been well received and we have heard very positive feedback from physicians and other members of the healthcare team.

Some interesting facts about the Adult Tracheostomy Care Team:

- The Adult Tracheostomy Care Team has followed 24 patients since October 2011.
  1 `qOf these 24 patients:
  - Five patients were decannulated on the wards
  - Four patients were discharged home with a permanent trach
  - Five patients have passed away
  - 10 patients are currently being followed
- As a result of the Adult Tracheostomy Care Team, patients are having their trach changed to a cuffless trach in a timelier manner.
- One patient had an airway obstruction (trach was occluded) with no adverse outcome due to the fact that the trach was cuffless and the patient could breathe through their upper airway.
- One of our patients with a long term trach (initial insertion 1993) was a moderately difficult trach change for the RTs. Through the trach team, we have tried different types of trachs, using a tube exchanger and administering Ativan prior to trach changes to make them easier for the patient. The patient has begun writing letters to the RTs regarding the frequency of her trach changes and what is working vs. what is not working for her. Even though she has had her trach for almost 20 years it is only now that she felt empowered to begin advocating for herself with regards to her trach management.
- The S-LP rep and RT educator created a handbook for patients going home with trachs that can be downloaded and printed from the hospital website when needed.

The Adult Tracheostomy Care Team had its first IPE lunch n' learn at the end of March where we discussed trach team outcomes and learned more about the S-LP role for trach patients. One of our Intensivists also delivered a presentation on the various complications that can occur with tracheostomies.

The main S-LP rep for the trach team is very interested in learning more about trachs and has observed several trach changes as part of her ongoing learning. Below is a reflection she provided on her experiences as a member of the Adult Tracheostomy Care Team.

As a Speech-Language Pathologist (S-LP) with an interest in tracheostomy and interprofessional practice, The Adult Tracheostomy Care Team has enabled me to actively pursue and further develop these interests. Meeting weekly to discuss patients who have tracheostomy tubes with RACE team physicians and Respiratory Therapists has provided me with ongoing opportunities for continued learning, consultation and observation all of which have greatly enhanced my understanding of tracheostomy care, respiration, oxygen and airway management, and pneumonia. This knowledge has undoubtedly improved my swallowing and communication assessments and interventions with patients who have a tracheostomy and facilitated better quality and patient-centered care. The Adult Tracheostomy Care Team has also allowed me the opportunity to educate Respiratory Therapists about the S-LP's scope of practice and facilitate a better understanding of the influence a tracheostomy tube has on a person's ability to swallow and communicate. This team has strengthened my belief in the value and benefit that comes with collaborative practice and team-based care, a vision The Credit Valley Hospital has put into practice.
-- Juliana Chris - M.H.Sc., S-LP Reg. CASLPO.

Roles and Scopes of Practice - Just Ask!

By Jennifer Harrison, RRT, Professional Practice Advisor

More and more RTs are finding themselves practicing in new and exciting roles in the hospital and in the community. From assisting doctors and dentists in their offices to Family Health Care Teams and Nurse Practitioner Led Clinics, RTs are proving themselves to be integral, accountable members of a variety of interprofessional health care teams.

Understanding and clarifying the roles of other health care providers and being able to express **your role as the RT**, are key factors that can support interprofessional collaboration (IPC) and lead to successful health care teams.

Did you know...

- Interprofessional care can help improve patient care while increasing provider satisfaction within a respectful and collaborative environment. (Health Force Ontario)

- **Groups** of people (including health care professionals) go through stages before they become **teams**. (Adapted from Bens, 2005. p. 63-64)

Group (comes together)	Exciting but sometimes frightening due to the unknown. "I-centred behaviour."
Forming	"New teams need clear parameters and relationship building."
Storming	Yes, this is normal! Be professional, don't give up and keep the conversation going.
Norming	"Requires honesty and disclosure."
Performing (Team)	Yes, it will happen. Don't forget to celebrate your successes!

- The CRTO's Position Statement Scope of Practice and Maintenance of Competency can support you to clarify your specific scope of practice in the context of your interprofessional team.

- The RT scope of practice in the *Respiratory Therapy Act (RTA)* is defined as:
  The practice of respiratory therapy is the providing of oxygen therapy, cardio-respiratory equipment monitoring and the assessment and treatment of cardio-respiratory and associated disorders to maintain or restore ventilation.

- Interprofessional Collaboration is a standard of practice for RTs. (Standards of Practice - Therapeutic Relationships p.14)

To learn more about the scopes of practice of other health care professionals, **just ask**. Initiating the conversation in your practice setting with the professionals you work with, shows leadership and a willingness to collaborate. It also gives you the opportunity to share what you do and to ensure others that you are an accountable professional.

The Federation of Health Regulatory Colleges of Ontario (FHRCO) has a list of all of the regulated health care professions' websites. You can find out about scopes of practice and authorized acts by opening the profession's specific Act. In addition, FHRCO is working on the development of practical tools that will facilitate health care providers to establish interprofessional teams and support collaborative practice in their unique settings. The CRTO is an active participant on this FHRCO IPC project.

To learn more about the context of different health care settings in Ontario visit the Ministry of Health and Long-Term Care's website at: *Learn About Your Options* http://health.gov.on.ca/en/public/programs/hco/options.aspx. Click on the icons to view e-learning videos.

We would like to hear from you. If you have any questions about interprofessional practice or would like to share your challenges and successes with us, please contact Jennifer Harrison, RRT Professional Practice Advisor at: Harrison@crto.on.ca or 416-591-7800 x 30.

References:

Bens, I. (2005). *Facilitating with Ease!* San Francisco, California. Jossey-Bass.

RTs in the Treatment and Management of Tobacco Addiction

By Shari Cole, RRT
Tobacco Intervention Clinical Coordinator, Regional Health Centre (NBRHC)

In the area of Nipissing/Parry Sound, our smoking prevalence of 26% is much higher than the provincial average. This means that roughly one in four patients admitted to our hospital will use tobacco. The health consequences of smoking are extensive, and of course are well documented.

RRTs (left to right): Joanne Tignanelli, Jillian Wilson, Shari Cole, Jamie-Lynn Linkie, and Diana Ammerata

At our hospital and others, we are fortunate to have partnered with the Ottawa Heart Institute, and offer tobacco intervention to in-patients using the Ottawa Model. Where NBRHC differs is that ours is an RT driven program; all 14 RTs on staff are educated in current best practice cessation strategies and are knowledgeable in brief tobacco intervention. As a department, we offer tobacco supports to patients 24/7, and provide about 130 in-patient smoking consults each month.

Our year-end numbers were also impressive; 98% of patients admitted to our program areas were screened for tobacco use on admission, and 96% of identified tobacco users received brief tobacco intervention by an RRT

Recently we have successfully implemented a certification process and medical directive that allows our hospital's RRT's to initiate Orders for Nicotine Replacement Therapy (NRT). This step has significantly reduced the time that patient's wait to receive NRT.

Lectures and moral judgements don't get people to quit smoking. The face of how we as health care providers address patient tobacco use has changed. The reality is that the vast majority of patients who smoke do want to quit. They are overwhelmingly open to talking about their tobacco use and welcome the advice and support we can give them. Believe it or not, this role has been one of the most rewarding I've had as a Respiratory Therapist.

While as a profession we include asthma education and COPD management within our scope of practice, for some reason RTs have not typically viewed supporting tobacco cessation the same way. Other disciplines have embraced this role, and are rising to the challenge. It is time for RTs to engage in what clearly falls within our area of expertise; health promotion through patient advocacy, education, and support for smoking cessation.

Erie St. Clair CCAC - Geriatric Rapid Response Team & Palliative Care Consultation Team (PCCT)

Mario Aquilina, RRT

Mario Aquilina is an RRT who has been hired by the Erie St. Clair Community Care Access Centre (CCAC) to work on two multi-disciplinary teams; the Geriatric Rapid Response Team (GRRT) and the Palliative Care Consultation Team (PCCT). His primary role is to assess Chronic Obstructive Pulmonary Disease (COPD) clients referred to the GRRT team and implement a COPD pathway. The pathway consists of a comprehensive assessment and teaching tool for clients with COPD. The ultimate goal is to assist clients self-manage their COPD and by doing so reduce hospitalizations and/or ER visits. Mario works in cooperation with community resources nurses, occupational therapist, family physicians, respirologists, and others allied health professionals. He also works with health centres and family health teams (FHT) in the area that have COPD education/exercise programs and, when appropriate, will refer COPD clients to their programs. His role on the PCCT team is to work with occupation therapists, nurse practitioners, social workers, chaplains and community nurses to assess and ensure the clients' respiratory needs are appropriately managed. In addition to filling this unique RT role in his local CCAC, Mario also sits on the Erie St. Clair Local Health Integration Network (LHIN) Health Professionals Advisory Committee and is a member of the Ontario Respiratory Care Society (ORCS) Southwestern Ontario Planning Committee as well as maintaining membership in the Canadian Society of Respiratory Therapists (CSRT) and Respiratory Therapy Society of Ontario (RTSO). Mario graduated from Fanshawe College in 1982 and has been a proud advocate for the profession ever since.

Respiratory Therapists & Indoor Air Quality (AQI)

Dave Leebody, RRT

Interprofessional collaboration [IPC] can involve many different ways of working with a variety of professionals. Dave Leebody is an RRT who graduated from the Michener Institute in 1987 and has worked extensively in the community sector in the provision of medical oxygen and respiratory supplies. He sold his home care company in 1995 and decided to move on and try something different. He is now certified as a Provincial Home Inspector with a designation of Registered Home Inspector [RHI] and is also nationally certified with a designation of Professional Home and Property Inspector of Canada [PHPIC].

In his role as a home inspector, Dave has received many calls with respect to **Indoor Air Quality [IAQ]** over the years and therefore has developed a keen interest in exploring this area further. He feels Respiratory Therapists are especially suited for this type of work because of their background in dealing with molds, asbestos, relative humidity, air filtration, etc. As community RT practice continues to evolve, Dave sees this as a unique opportunity for RTs to become more involved in indoor air quality inspection.

If you are interested in learning more about this exciting area of practice, please see the Ontario Association of Home Inspectors website.

The St. Michael's Hospital Student Café

By Pam Greco, RRT & Kerri Porretta, RRT

Recognizing the importance of both interprofessional collaboration (IPC) and interprofessional education (IPE), individuals at St. Michael's Hospital (SMH) had a concept in mind for an initiative that would meet these needs. In order to help launch this project, SMH sent an interprofessional team to the *Educating Health Professionals for Interprofessional Care* (EHPIC) course at the University of Toronto in June 2010. The team was comprised of representatives from Respiratory Therapy (Pam Greco, RRT), Medical Imaging (Spring Crabbe, MRT(R)), Social Work (Colette Deveau, RSW), and Spiritual Care (Peter Thompson). The goal of this five-day intensive training course was to develop leaders in IPC and IPE. Participants gained knowledge, skills and attitudes that would allow them to teach both learners and fellow colleagues the art and science of working collaboratively for patient-centred care.

Armed with new knowledge and an enthusiasm to translate learning into practice, the IPC team set out to develop this concept into a tangible initiative which would provide an opportunity for others to benefit from interprofessional collaboration and education experiences. The group, working in conjunction with input from another health discipline professional (Ellen Newbold, PT), came up with an intriguing and creative opportunity to engage students in interprofessional discussion, learning and collaboration and called it the Student Café

The Student Café is a scheduled, facilitated discussion which now occurs on a monthly basis. It is a safe environment where students (any trainee from any discipline within the institution) can meet, reflect, discuss and develop their practice in an open forum of clinical experiences. The sessions are facilitated by the founding group of interprofessional collaborators, and have a rotating set of themes (which include such topics as: "What is it like working with critically ill patients and their families?"; "What happens when the unexpected happens?" and "When the team disagrees").

The Student Café sessions have become a key part of a student's interprofessional education, and as such have been recognized by the University of Toronto to receive Points for Interprofessional Education System (PIPEs) credits. The café continues to evolve based on the feedback from session attendees.

Staged Hazardeous Materials (HAZMAT) Event at Conestoga College Institute of Technology and Advanced Learning

By Lori Peppler–Beechey, RRT, Program Coordinator, Respiratory Therapy

On April 3, 2011, Conestoga College Institute of Technology and Advanced Learning (Doon campus) was the scene of a simulated large scale HAZMAT exercise implemented by the Waterloo Interprofessional Healthcare Student Collaborative (WIHSC). WIHSC is an interprofessional collaborative of health care students from Conestoga. It was formed early in 2009, and includes students from many health care disciplines including Nursing, Respiratory Therapy and Community Safety programs. The purpose of WIHSC is to foster interprofessional collaboration by providing educational opportunities that enable a greater understanding the roles and responsibilities of a wide variety of professions. A multi-agency emergency response situation, such as the one held on April 3 last year, offered Conestoga students a unique experience creating the opportunity to apply knowledge into practice.

The simulated hazardous materials event was staged with the assistance of 15 organizations, such as Kitchener Fire Department, Waterloo Region EMS, Waterloo Regional Police Service, St. John's Ambulance and Red Cross. Conestoga students served as "patients" who were triaged, decontaminated and transferred to a hospital created inside of E wing of the College. Respiratory Therapy students worked alongside students from the other health discipline programs to provide care to those injured in the simulated incident.

The event was a success with almost seamless transition of patient care from one healthcare service to the other. All those involved found it to be an incredible learning experience and it is hoped that a similar scenario can be replicated in the future. You may click on the WIHSC website to learn more about the organization and to see a video of the HAZMAT scenario.

The CRTO Quality Assurance Program: Past, Present & Future

In the rapidly changing landscape of healthcare, it is essential for Respiratory Therapists (RTs) to continuously strive to ensure that their knowledge and skills are up-to-date. The primary goal of the CRTO's Quality Assurance (QA) Program is to support its Members in this process of ongoing professional development. The *Regulated Professions Health Act* (RHPA) mandates that each health regulatory College's Program consist of specific components and that its Members provide evidence of participation in the Program. However, the vision of the College's QA Program remains the same: **to assist RTs in continually enhancing their ability to provide safe and ethical care**.

Evolution of the QA Program – 1994 to Today

Since the inception of the College, the QA Program has undergone a number of significant changes and there have been some successes as well as a few challenges along the way. The Continuing Education for Respiratory Therapists (CERT) credit program, which was the CRTO's preliminary QA tool, was eventually replaced with the Core Competency Evaluation (CCE). When it became apparent that a revision of the College's QA processes was in order, the Fresh Start initiative allowed the CRTO to take a step back and establish a more values-based vision of the Program. It was evident that what was most crucial was to create a QA Program that met both the requirements under the RHPA and the needs of our Members. This led to the CRTO's current QA Program.

We believe that in order to create a QA program that truly meets these requirements, we need the direct involvement of our Members. That's why the core principle of the CRTO QA Program is: **collaboration through consultation and engagement**.

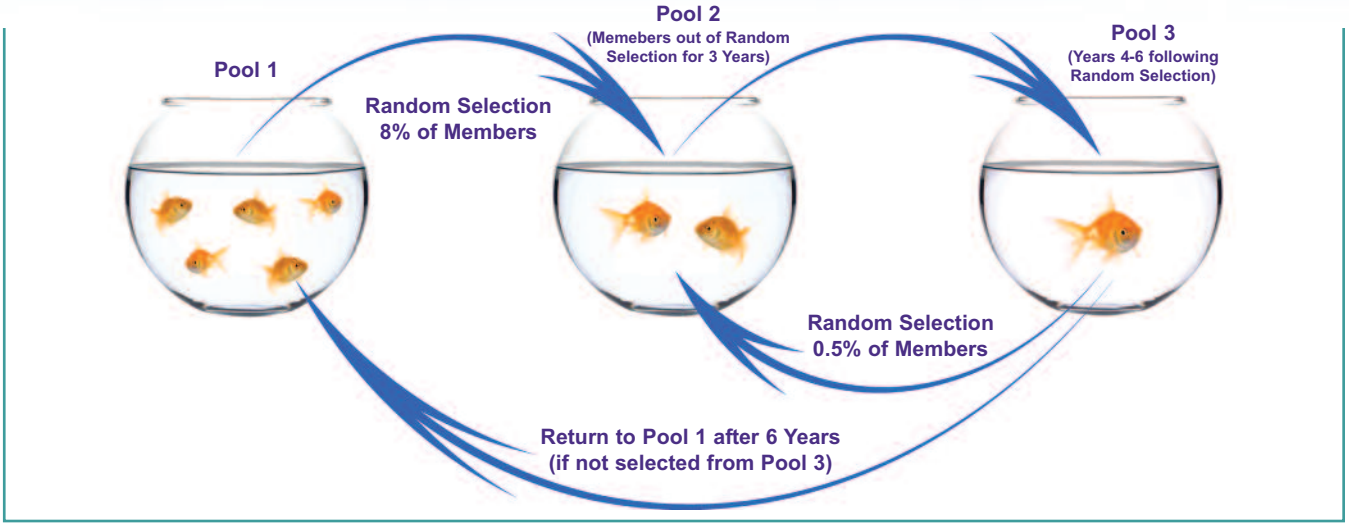
Random Selection - How It Works

Random selection occurs in the fall, when 8.5% of the membership (approximately 215 RTs) are selected annually to complete the PSA and submit their PORTfolios. The random selection is run through a computer script on the Member database. It is programmed with the criteria, as outlined below, then we run the script and the computer will produce a list of Members that are picked for the current years' selection. Initially there were only two pools of Members:

(1) those who had been selected within the past three (3) years, and
(2) all other Members, both Active and Inactive.

Based on feedback received from the Members during the 2008 QA Program Evaluation, we realized that we needed to make some changes to the random selection process. So, beginning in 2009, all Members who held Inactive status were exempt from the random selection process. Also in 2009, we took steps to reduce the number of Members reselected within the previous 6 years. This resulted in the current random selection process:

- 8% are selected from pool #1 which consists of Members who have not been selected for QA in the last 6 years;
- No Members are selected from pool #2 which consists of those Members who have been selected within the past one (1) to three (3) years; and
- 0.5% are selected from pool #3, which consists of Members who have been selected within the past three (3) to six (6) years.



Components of the QA Program

As noted, the RHPA (s. 80.1 of the *Health Professions Procedural Code*) sets out the minimum requirements for QA Programs. They must include elements that support:

- Professional Development;
- Self, Peer and Practice Assessments.

Within this framework, each College must then determine what process will meet their obligations under the legislation, while also accounting for the unique characteristics of each particular profession.

In compliance with the RHPA, the CRTO's QA Program currently consists of the following three (3) components:

1. Portfolio Online for Respiratory Therapists (PORTfolio);
2. Professional Standards Assessment (PSA); and
3. Practice Assessment.

CRTO QA Program Components	Addresses the following requirements:			
	Professional Development	Self-Assessment	Peer Assessment	Practice Assessment
PORTfolio	✓	✓	✓	
PSA			✓	✓
Practice Assessment			✓	✓

The CRTO Quality Assurance Program: Past, Present & Future *(continued)*

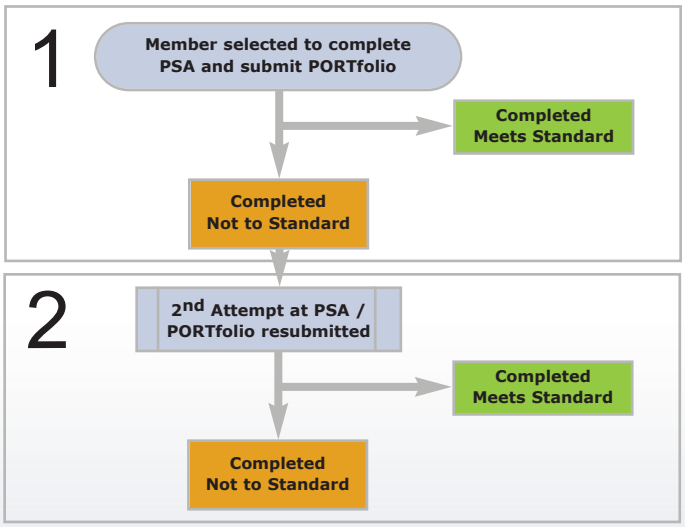
Assessment Criteria

To ensure fairness and consistency, all the components of the current QA Program are assessed using established criteria developed and approved by the Quality Assurance Committee (QAC). This assessment criteria is as follows:

- **PSA** – the Benchmark for successful completion is 70% or above the 6th percentile, whichever score is lower for a given year;
- **PORTfolio –** the PORTfolio Assessment Criteria has been created to provide a priority weighting to the various elements of the PORTfolio; and
- **Practice Assessment –** a Practice Assessment Checklist has been developed to provide the framework for this assessment, (available on the CRTO website in the near future). Because this component of the QA program would be utilized rarely and only in certain unique instances where it was deemed necessary, the specific standards by which the Member would be assessed would depend on areas for improvement identified in the PSA and/or PORTfolio.

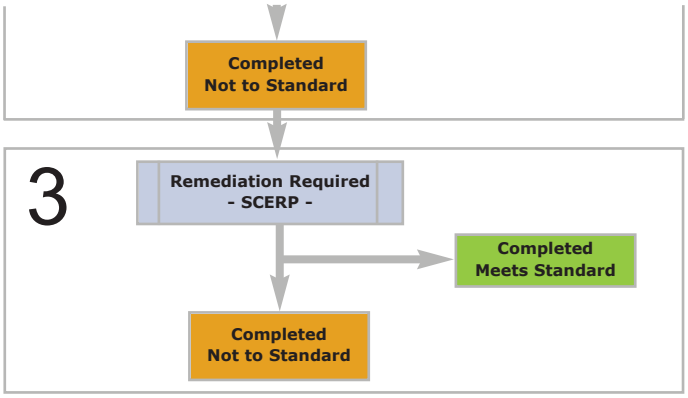
Laddered Approach

To implement these assessment tools, the CRTO has adopted a "laddered approach". The standard QA components utilized for all CRTO Members on a regular basis are the PSA and PORTfolio. Members are given two opportunities to meet the benchmark of the PSA and the established criteria of the PORTfolio. Between the first and the second attempts a Member is given an opportunity to consult with College staff to determine how best to meet the necessary criteria.

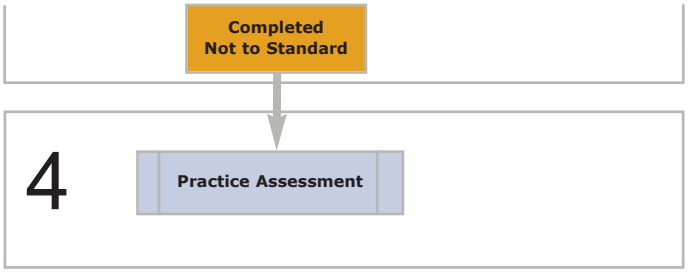


The CRTO Quality Assurance Program: Past, Present & Future *(continued)*

If a Member is unable to successfully complete either or both of these components after two attempts, then it is necessary to provide them with an opportunity to improve their knowledge, skills and judgment before any further assessments are undertaken. This is done through a SCERP (Specified Continuing Education or Remediation Program). A SCERP is an educational program that is customized to the Member's learning needs that were identified in their previous assessment(s).



Once the SCERP is completed, the QA Committee makes a determination as to how successful the learning session was in enhancing the Members knowledge, skill and judgement. If it is decided that further assessment is necessary, there are several options available to the Committee. One of those is for the Member to undergo a **Practice Assessment.** This assessment would be conducted at the Members practice site (or other appropriate location) and facilitated by an RT who has been trained as an assessor.



It is important to understand that the ability for the CRTO to require a Member to undergo a Practice Assessment as part of the QA Program is not new. Practice Assessments have been an option under the RHPA since its inception in 1991. The example on page 15 illustrates the process that a Member would go through before a Practice Assessment would be considered to be necessary.

Overall QA Program at a Glance

Case Example of QA Program

Member X was randomly selected to complete the PSA and submit her PORTfolio in September 2011. Two days after her login and password to access the PSA were emailed to her she completed the online test. Here score was 23/50. College staff contacted her to let her know that the benchmark is 70% or the 6th percentile (whichever is lower), and that 46% would undoubtedly be below that threshold. Would she like to re-take the PSA prior to her results going to the QA Committee for consideration? "Yes", says Member X. Just over two weeks later she completes the PSA for a second time. Her score is 26/50.

Several weeks later the QA Committee meets to review the scores of all Members who were randomly selected and review the PORTfolio results based on the PORTfolio Reviewers' assessments. Member X's second PSA score also falls below the 6th percentile, and her PORTfolio is determined to be unsatisfactory. The Committee asks the Manager of QA & Member Relations to provide some assistance to Member X (by phone or in person), and requires Member X to attempt the PSA a third time and to resubmit her PORTfolio in six months.

When the six month deadline comes, Member X has resubmitted her PORTfolio and PSA as required. Unfortunately, her PORTfolio again contains a learning goal that is not relevant to her practice, nor explains how patients will benefit from her endeavour. Her PSA score is once again 26/50. When the QA Committee reviews these results they direct Member X to complete a SCERP (specified continuing education or remediation program). The SCERP consists of meeting with an RT who is a member of the QA Committee and the Manager of QA & Member Relations. Member X is given three exercises to do in advance of the meeting; they focus on the three topics that she consistently scored poorly on in her PSA attempts. At the meeting they discuss the Professional Practice Guidelines and scenarios from the exercises. In addition they practice identifying and writing learning goals.

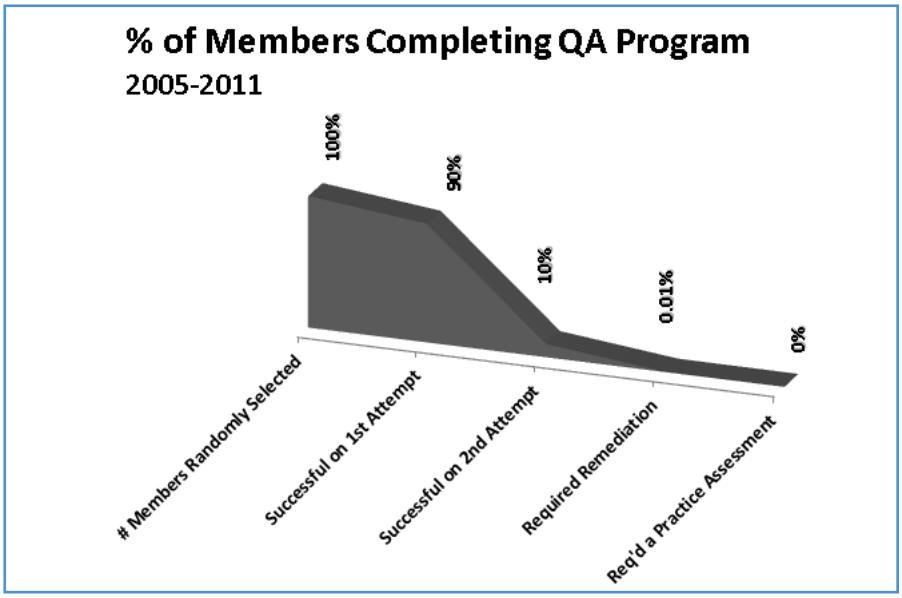
At the end of the 4-hour meeting with Member X, the QA Committee member and Manager of QA & Member Relations write up a report on how the meeting went. Unfortunately, Member X had not completed the three exercises in advance of the meeting and by the end of the meeting still did not demonstrate an understanding of what is required in a PORTfolio. When the QA Committee meets again and reviews the report they struggle with what to do next. While recognizing that some people have difficulty writing multiple choice tests, and that a meeting with College staff and a Committee representative could be stressful, they are left with unsatisfactory results on two components that over 90% of RTs complete successfully on their first attempts. Given their mandate the Committee decides that to be assured that Member X is practicing safely, the best option would be to observe Member X in her practice and orders a Practice Assessment.

The CRTO Quality Assurance Program: Past, Present & Future *(continued)*

Members Performance on QA Program 2005-2011

Since 2005, 1,301 Members have been randomly selected. The results show us that RTs are overwhelmingly meeting the standards for the QA program. Specifically:

- Over 90% of the PSA and PORTfolio submissions were at or above the standard for completion;
- Of the remaining 10%, nearly all met the standard on their second attempt;
- Less than 0.01% of those randomly selected required remediation to meet the standard;
- No practice assessments have been required to date.



QA Program Evaluation

The following is a chart illustrating the actions taken on the recommendations made by Members in the 2008 QA Program Evaluation Report.

Recommendations	Actions
Develop and publish a position statement/paper on the Goals of the QA Program.	CRTO published Communiqué on The New Vision of the CRTO Quality Assurance Program
Provide randomly selected Members with a list of Assessors for the purpose of identifying conflicts of interest.	List of RT PORTfolio Reviewer provided to Members in their notification of Random Selection as of September 2008.
Develop a web-based Professional Portfolio.	PORTfolio Online for Respiratory Therapists launched in spring 2010.
Incorporate examples of Learning Goals and Learning Activities of Members who are in a variety of practice settings, including non-direct patient care roles, in future versions of the Professional Portfolio form.	A number of examples are provided to assist Members in completing both the Learning Log and Learning Goal sections of their PORTfolio (spring 2010).

The CRTO Quality Assurance Program: Past, Present & Future *(continued)*

Recommendations	Actions
Review the practice of selecting Inactive Members in the random selection process.	Council approved a motion in 2009 to have Inactive Members removed from Random Selection Process.
Review the random selection process to investigate limiting the number of times a Member can be selected and increasing the percentage of Members who have not previously been selected.	3-pool system was adopted in 2009 with the intent of decreasing the number of Members who were reselected.
Monitor the French translation process to ensure that Members who prefer to receive communications from the College in French have equal access to all QA Program components.	A parallel French version of the PORTfolio was launched in the fall of 2011. Work has begun to provide an online French version on the PSA to be completed for the fall 2012.
Review the Self-Assessment section of the Portfolio with the intention of facilitating Members' skill development (patient related, changes in technology or other) as prescribed in regulation; "assessment of members' knowledge, skills and judgment".	The Self-Assessment portion of the PORTfolio was revised for the online version. The QAC continues to explore ways to refine the self-assessment process to ensure that it provides Members with a valuable means to determine their learning needs.
Ensure compliance with the Regulated Health Professions Act amendments.	The QAC determined that it met and continues to meet the necessary requirements under the RHPA.

Looking Forward

"Excellence is the gradual result of always striving to do better." Pat Riley

The CRTO is continuing to look for ways to make the QA Program more efficient and effective. Here are just a few of the enhancements that are underway for 2012:

- Integration of PSA into PORTfolio platform in both English & French;
- PRINT function added to the PORTfolio;
- QA Portal on the CRTO website that will enable Members to:
  - see if they have been randomly selected for a given year; and
  - access the PSA and PORTfolio and view their assessment results.

In 2013, the CRTO will be once again undergoing a large scale evaluation of its QA Program; this time looking at the years from 2008 – 2012. CRTO Members, both those who have been selected to complete the Program requirements within that time frame and some who have not, will be asked to provide their perspectives on the QA Program. This feedback is essential to ensure that the Program meets the needs of the Membership going forward.

We welcome the input of Members at any time. If you have any questions, comments or concerns, **please contact Carole Hamp RRT, Manager of Quality Assurance & Member Relations** at hamp@crto.on.ca or 1-800-261-0528 x33.

Cultural Competence "One Educator's Learning Journey"

By Sean Martin, RRT

As the son of two healthcare professionals (one an educator), I have always had a strong interest in clinical education. With this interest deep at heart, I set forth on a clinical and academic career with one goal in mind; to become a health education leader. After joining SickKids in 2003 as a staff therapist, I was able to develop the clinical experience and knowledge that is the foundation of effective educators; however, given the importance of evidence in developing effective curriculum and practice, I realized early on that research experience would be a valuable asset as both an educator and clinician. Fortunately, as SickKids is Canada's most research intensive hospital, over nearly three years as a Clinical Research Project Coordinator in the Division of Respiratory Medicine-Lung Biology Program, I was able to gain that experience. This opportunity left me with a strong understanding of the complex clinical research process, and the importance of study design in seeking answers to the questions of best practice (and being published was certainly a nice perk!).

> *"In developing effective curriculum and practice, I realized early on that research experience would be a valuable asset as both an educator and clinician."*

Always seeking opportunities to be involved in education, I jumped at the chance to be SickKids RT Clinical Instructor and Clinician Educator. In this role I was able to collaborate with academic institutions and gain a greater understanding of the clinical education process for both staff and students. Also, within this role I had the opportunity to Co-Chair SickKids Resuscitation Advisory Group which further developed my skills regarding organizational education and practice leadership. Although my clinical and work experiences were providing wonderful learning opportunities, an academic piece remained missing, so, in 2007 I enrolled in the Master of Health Studies – Leadership (Education focus) Program through Athabasca University's Centre for Nursing and Health Studies. Completed in 2011, this degree provided the theoretical and evaluative knowledge to take a greater role in education development and leadership, and kept me on par with my interprofessional educator colleagues. Certification in Interprofessional Collaborative Change Leadership through the University of Toronto also provided the opportunity to learn more about change leadership while networking with professionals from across Ontario (including RTs). With my clinical and academic experiences in hand, in 2009 I joined SickKids Learning Institute as a Clinician Educator, and New Immigrant Support Network (NISN) as an Interprofessional Education Specialist. Within these roles I have taken on greater leadership responsibilities, in particular in regards to resuscitation education and clinical cultural competence education, including developing and delivering clinical cultural competence Train-the-Trainer workshops across Ontario, presenting at conferences, writing manuscripts, and partnering with stakeholders to develop innovative ways to advance practice and outcomes through effective education and knowledge dissemination.

Interestingly, when I reflect on the path I have taken, the power of culture in all that we do as

Cultural Competence
"One Educator's Learning Journey" *(continued)*

therapists has become all the more clear; a fact that had escaped me prior to my work in the NISN. Although we rarely realize it, on a daily basis we are required to navigate professional cultures, organizational cultures, and academic cultures, all within the context of Western medical culture; a culture that has historically defined expertise as something "owned" by the clinician and gained through the combination of evidence research and formal education. However, what I have come to understand more clearly is that one's expertise is of no value if that of the "other" is not valued, whether the other is a patient, student, or colleague. In terms of best practice, we know that the safety and quality of care is improved when patients' cultural considerations are sought, valued, and incorporated into the care plan. In parallel, I would argue that all the experience and training in the world will not be enough for the future of our profession if we fail to consider not only our professional values and beliefs, but also those we have as individuals and the role they play in practice, education, and research. Working in Ontario we have the unique responsibility of practicing in a province that became home to nearly half of all Canadian newcomers in 2011. This diversity is not only reflected in the patients we treat, but also among our interprofessional colleagues and leadership. Thus, at all levels we must incorporate an understanding of culture in both daily practice and as we strategize the most effective ways to prepare current and future RTs for the realities of interprofessional practice in Ontario. Although often invisible, cultures are at the heart of interprofessional collaborative patient and family-centred care and they must not be ignored, whether we are direct care providers, educators, students, or leaders. Ultimately, success will be measured by our ability to not only navigate a multitude of individual, professional, organizational, and patient cultures, but also in our ability to incorporate the knowledge they each hold in the aim of achieving the vision they each share, that of optimal health.

> ***"At all levels we must incorporate an understanding of culture in both daily practice and as we strategize the most effective ways to prepare current and future RTs for the realities of interprofessional practice in Ontario"***

For more information regarding clinical cultural competence and access to free educational resources, please visit www.sickkids.ca/culturalcompetence.

Upcoming Events

Throughout the year the CRTO is notified of several events that are of interest to RTs. We post these opportunities on our website at www.crto.on.ca/events.aspx.

Please remember that you can use the AHPDF to apply for reimbursement for the cost of a conference!

Professional Practice FAQs

Jennifer Harrison, RRT
Professional Practice Advisor

Case Study

I am an experienced RT who has worked most of my career in a hospital with a very busy labour and delivery unit and a level III NICU. I have intubated many newborns in my career! I recently moved and started a new job at my local community hospital. In this setting, there is a small labour and delivery unit and the RTs are expected to attend all high risk deliveries. It is an organizational requirement for RTs to become certified in neonatal intubation and RTs may intubate according to a medical directive that is in place. As part of the certification process, we all have NRP training and must perform three successful intubations under the direct supervision of an attending pediatrician or their designate. ***If I was called to assist at the delivery of a baby presenting with severe meconium aspiration syndrome and I knew that the best course of action would be for me to intubate and suction the baby, could I go ahead and intubate even if I had not completed my hospital's certification process yet?***

Answer

The scenario that you outlined certainly poses an ethical dilemma, because there is an expectation that you meet your employer's requirements that is, the three supervised intubations you describe. However, if you have not yet been certified by the hospital and are faced with a situation such as you described (severe meconium aspiration), AND you are of the professional opinion that the infant requires intubation as a life-saving measure, AND you are competent to do so, then it would be appropriate to take such action. Should you choose to not intubate for fear of repercussion and the infant dies as a result, your professional judgement would likely be questioned. Alternatively, if you decided to intubate and the infant died regardless of your life-saving efforts and a complaint/investigation occurred, your defence would be that: 1) it was your professional opinion that intubation was necessary (that the baby would likely die without it), and 2) that you were competent to perform intubation.

The expectation is that you make every effort to meet the hospital's certification requirements as soon as is reasonable in order to avoid these types of dilemmas. As a reference you may wish to refer to the College's *Commitment to Ethical Practice* which includes a decision tree for situations like you described.

Remember, your employer may have policies related to your authority to perform procedures including controlled acts, authorized acts and acts that fall within the public domain. If your employer's policies are more restrictive than the College's requirements— you should abide by your employer's policies. Where your employer's policies are more permissive than the requirements of the College — you must adhere to the requirements of the College. (*PPG Interpretation of Authorized Acts*, p.13)

Take a Moment...

An opportunity for RTs to reflect on their practice

Take a Moment… is just for you. The self-directed learning activities are intended to give you the opportunity to review and familiarize yourself with the College's standards of practice and to connect them to your own practice of Respiratory Therapy. The questions are reflective in nature and promote critical thinking. You may end up confirming that you have a great understanding of the College's standards and exceed them day-to-day or, you may find that you would like to enhance a particular aspect of your practice for example, communication skills.

Steps

- Read/review the suggested document: Responsibilities Under Consent Legislation.
- Read the learning activity right through from start to end.
- Take a moment to reflect.
- Answer the questions.
- File your completed activity away for your own personal use if you choose to.
- You may also choose to include this activity as part of your QA Learning Log.

Remember, if you act within your scope (where you feel competent and can ensure accountability), stick to the standards of practice and commit to maintaining competency (QA) you will find that self-regulation can be empowering and that you can make a difference.

Take A Moment... Responsibilities Under Consent Legislation

Informed Consent
Informed consent is based on the concept that every person has the right to determine what will be done to his or her body. This is the principle of autonomy.

1. **What are the elements of consent? Why do you think these elements are important to patient-centred care?**
   Hint: Principle of autonomy.
2. **Differentiate between implied consent and expressed consent. Give an example of each from your practice.**
3. **Can you describe a moment where you were not sure if informed consent had been obtained?**
   Hint: Informed consent relies on the principle that information about the treatment or treatment plan has been received and understood.
4. **What did you do? What would you do differently now that you have reviewed the standards of practice?**
5. **What did you think about the case study "A case of questionable O2" (p.10)?**
   Hint: What were the practical challenges and ethical dilemmas the RT had to face in making their decision to do the right thing?
6. **RTs are not authorized to perform formal capacity evaluations or assessments (see pp. 9-10). Given a scenario where you are unsure that a patient/client is capable to provide informed consent, what would your course of action be?**
   Hint: Speak to some colleagues, check your hospitals policies and procedures.
   Hint: Review the purposes of the Health Care Consent Act (HCCA) and the Substitute Decision Act (SDA) (p.4).The HCCA presumes a person is capable (p.6) where the SDA deals with decision making on behalf of an incapable person.
7. **Given that consent depends on the treatment and the timing. What would you do if you noticed your patient's capacity to provide informed consent changed with his/her deteriorating health?**
8. **What do you think will happen if you do not perform intubation given that you are confident that an informed decision with respect to CPR has been made and that you have met all of your profession's standards of practice regarding accountability, communication and documentation?**

Registration Changes

September 1, 2011 to February 29, 2012

New Members

The College would like to congratulate and welcome the following new Members:

General Certificates of Registration (RRT) Issued:

AMARSI, Fatima
ARMSTRONG, Joel
BERÉNYI, Angéla
BERKELMANS, Nicole
BOURASSA, Steve
BRADLEY GARTON, Jennifer
BRAR, Navjit
BROWN, Amanada
BURNS, Matthew
CATT, Spencer
CHIN, Calvin
CODLING, Cailin
COSTANZO, Loriana
CULP, Stacey
CUNNINGHAM, Monica
CURRIE, Carolyn
FORSTER, Scott
FRANCIS, Jennifer
FRANK, Erik
GAUTHIER, Tania
GIACOMINO, Brittany
GIBSON, Kevin
HERTEIS, Rachel
HOLT-HINDLE, Andrew
HOUSSAMI, Nagham
IRELAND, Chantelle
ISAAC, Lindsay
ISAAC, Sarah
JOO, Tanya
JULL, Paula
KALONDA, Tatiana
KENDALL, Aaron
LOD, Elizabeth
MACDONNELL, Cory
MACZAK, Veronika
MATHEW, Jeff
NEWMAN, Shauna
PARKER, Kelly
PAYSON, David
POISSANT, Richer
PRINCE, Golda
RAFAEL, Jasmine
RAUCHE, Jasmine
REXHEPI, Fatmire
SAWATZKY, Brea
SIDER, Jordan
SIDHU, Poonam
SONG, Min Hee
ST-ONGE, Roch
STIPSITS, David
SUN, Xiaoya
TINANI, Naresh
VALADKA, Vilija
VARATHARATNAM, Shayana
WONG, Jenny
WROBEL, Holli
YEW, Jeremy

Graduate Certificates of Registration (GRT) Issued:

HILKER, Kristine
INGLIS, Leanne
POITRAS, Mélika
PRUNEAN, Marius
RAMSEY, Michelle
VUONG, Tony

Resigned Members

General

AIKEN, Stacy
DALLAIRE, Rhonda
DAWSON, Mary
ESPENA, Lilia
FAUCHER, Stephanie
GAUTHIER, France
HELLER, Linda
HORTH-SUSIN, Lise
HUTCHENS-RICHMOND, Linda
JEAN-BAPTISTE, Germain
JOHNSON, Dianne
KRAGH, Heather
LAWRIE, Kathryn
LIN, Jeff
MACDONNELL, Cory
MISETICH, Anamaria
NICOLETTI, Valeria
PUMPHREY, Nancy
REDPATH, Sydney
REID, Robert
SAKAKI, Beverly
THUSS, Kaitlyn
VANDEKERCKHOVE, Rhona

Graduate

CULBERT, Cara
GINGRAS, Marie-Eve
GRAHAM, Kyla
PATTERSON, Danielle
WILKINS, Brandon

Limited

BARKER, Anita

Revoked Members

under Registration Rules

General

AMOAKO, Maxwell
ANANIA, Shawn
ASUCHAK, Benjamin
BEAUPRE, Jerome
CAIN, Jeffrey
CLOUTIER, Katia
DEBRINCAT, Petra
FRASER, Judith
GRINEVSKY, Bracha
HUYNH, Eric
ISRAEL, Emily
JUNLAJEAM, Kreaksuk
KRUSCHINSKE, Paul
LALONDE, Roch
LE, PHUONG Lan
LIU, Junling
LO, Priscilla Kar Yee
MAI, Dong Qing
MALO, Monique
MBOMBO, Mediatrix
NATTRASS, Elan
PROVENCHER, Elise
QURESHI, Anis
ROBERTSON, Denise
ROBERTSON, Gordon
ROCK, Tania
ROY-BRAY, Brigitte
RYAN, Veronica
SAMUEL, James Anslem
SARNACKA, Eva
SHANMUGATHASAM, Preshanthini
SMITH, Mariah
STEWART, Scott
THEORET, Ella
TODD, Christina Marie
TURCOTTE, Shawn
VAN LOON, Alexander
WOODMAN, Rebekah

Graduate

BUGARIN, Maritess
MAMARIL, Arvin

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