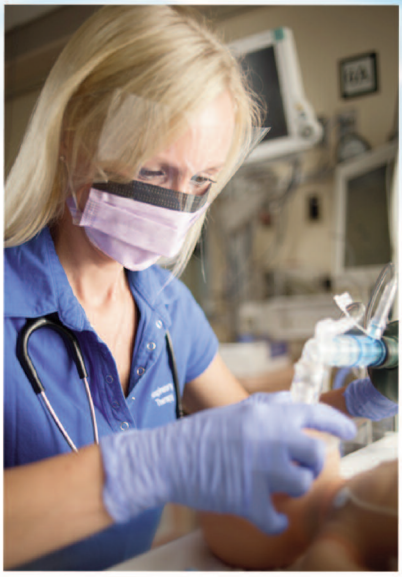
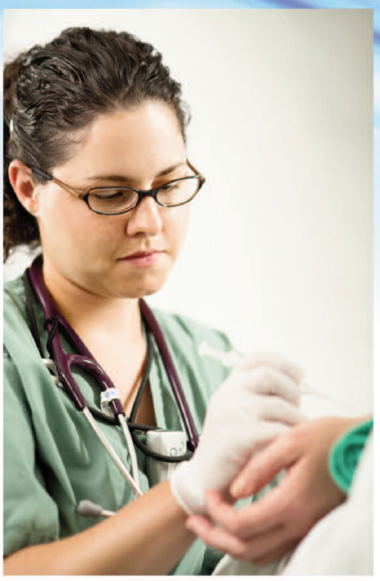
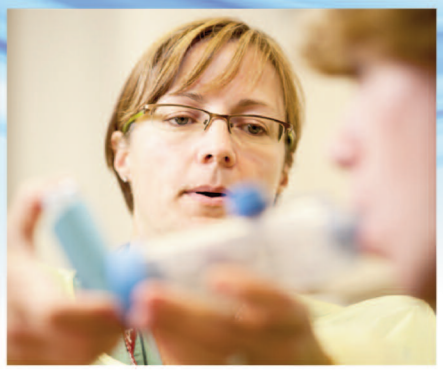
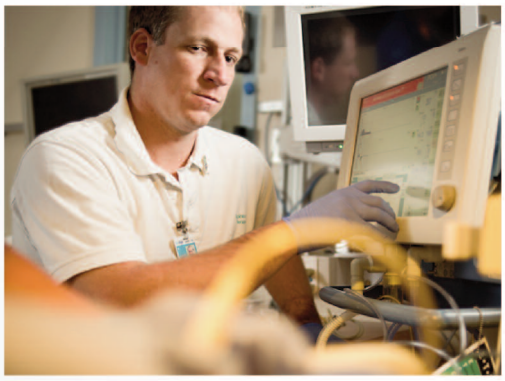
eExchange

The Newsletter of the College of Respiratory Therapists of Ontario




College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

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FOCUSING ON COMMUNITY CARE

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RTs in the Community: The New Frontier

One of the great strengths of our profession is the range of practice environments where we can apply our skills. In our CRTO Annual Report last year, we cited 24 different main areas of practice, as reported by our members, with these areas ranging from Acute Care to Education, and from Pulmonary Diagnostic to Sales. It should come as no surprise to hear that nearly 85% of all RTs work in a hospital setting with the vast majority of those working in some element of acute or critical care. The remaining 15% tends to cluster around care based in the community. Hold onto that thought.

There is an interesting change happening in Ontario right now. The population is aging, with the number of seniors aged 65 and over expected to more than double to represent 23.6% of the population in the next 20 years. With nearly half of the RTs in Ontario falling under the age of 40, it is sobering to think that this senior "boom" will occur during our professional career. At the same time, we are seeing an increasing prevalence of respiratory disease, with 80% of seniors over 65 having at least one chronic disease, most commonly respiratory disease. Combined together, an aging population and increasing prevalence of respiratory disease represents a coming tsunami for our healthcare system. There is no question that these individuals will require care - the interesting question is who will provide that care?

There is currently a system-wide shift in healthcare to ensure better access to healthcare services for all Ontarians, with an emphasis on consumers of the healthcare system becoming better educated about their health and better able to make choices pertaining to what kind of care they wish to receive, where they wish to receive it, and by whom. There is an expanding range of care locations that exist as an alternative to hospital-based care, whether it's an outpatient clinic focusing on colonoscopies or primary care clinics led by Nurse Practitioners. There is an increasing awareness that staying in a hospital for a long period is not necessarily good for your health (think, nosocomial infections) in addition to being costly. We're beginning to understand as a system that *Quality drives cost* and, with costs expected to continue to grow for health care, finding ways to provide better quality care is no longer an option – it is an imperative. Taken together, the future is clear. Quality care in settings other than hospitals is going to be an area of emphasis and growth for the healthcare system that we all work within....and the seeds for this growth are being sown right now.

Let me pull together the three strings – we have an RT workforce with the skills to manage respiratory disease, but they are primarily hospital based; there is an unprecedented increase in demand for respiratory care coming, and it will arrive within our professional lifetime, and there is a growing shift of services away from hospitals in response to societal expectations, cost containment, and in anticipation of the need for more services in the community. There is only one conclusion to all of this: Community-based care is what our patients need and we have the skills to meet those needs. Put another way, community-based care truly represents the new frontier for Respiratory Therapy. There is an opportunity to contribute to the taming of this frontier by being an early contributor, by showing the possibilities and helping to develop the models of care that will become the standard for the community in the future.

Now, we already have an incredibly talented and dedicated group of RTs providing care in the community, and they have been pioneers in this area. But we'll need more, and we'll need RTs in places they haven't been before. Yet, with most of us working in a hospital, this new frontier represents a great unknown, something we don't really understand, and we'll need to if we're to rise to this challenge.

So, this issue of the Exchange is devoted to the topic of care in the community. You'll find several articles that only scratch the surface but will hopefully provide you with a small glimpse of care in the community setting – the new frontier for Respiratory Therapy.

Respiratory Therapists in Family Health Teams

Elizabeth Cochrane, RRT

By Elizabeth Cochrane, RRT
Human Resources Administrator
Maple Family Health Team, Kingston

Family health teams (FHTs) have been a large part of primary care in Ontario since 2005. Presently, there are about 170 FHT's providing care to millions of Ontarians[1].

Data collected by the CRTO indicates that there are approximately 32 Registered Respiratory Therapists (RRT) working in family health teams in Ontario and most are providing asthma education, COPD education and smoking cessation counselling. Asthma and COPD education includes diagnostics, spirometry, self-management counselling, medications review, trigger awareness education and action plan development. No doubt, family health team RRTs are also engaged in other activities such as sleep therapy counselling, home assessments, staff education, and management of patients with other respiratory diseases besides asthma and COPD.

Though procedures and diagnostics play a large part in the RRT function, I believe that patient education is the hallmark of the role RRTs perform in primary care. When a patient has just received a diagnosis of asthma, for example, he will receive information about the disease process, learn how to recognize an impending exacerbation, receive tips on how to take his puffers correctly, and find out how to eliminate or decrease his exposure to triggers. In addition to the information I can give him as the RRT, I can refer my patient to the Registered Dietitian, Pharmacist, Social Worker, Psychologist or Physiotherapist on the Team for further assessment and education.

As RRTs, we are expected to consider on a daily basis if our actions will benefit patient care. In the same respect, administrators must ask themselves the same question when considering a staffing or program change. How will adding a Respiratory Therapist to the family health team result in better patient care? If a physician can refer a patient to the PFT lab across town, or the local respiratory education centre, what is the benefit to having an RRT on staff?

I believe that there are many benefits to having a Respiratory Therapist embedded in the family health team, but to keep this article short I will describe the obvious one; an improvement in communication. Better

[1] Ministry of Health and Long Term Care (2012, June 25). Family Health Teams. [Website]. Retrieved from http://www.health.gov.on.ca/en/pro/programs/fht/

Respiratory Therapists in Family Health Teams

communication results when the RRT and the responsible practitioner are located at the same site. The benefit to face-to-face hallway conversations cannot be duplicated over the phone, fax or e-mail. In addition to the obvious benefits to rubbing shoulders with others in the circle of care, using a common electronic medical record program helps to speed up the referral process, allows the RRT access to relevant documents in the patient record and allows the respiratory care note to land directly in the physician or nurse practitioner's in-box, leading to a quicker turn-around time for orders.

I'm not suggesting that family health teams should put PFT labs or respiratory education centres out of business. There are plenty of patients who will require specialized care due to the advanced stage of their disease, a poor response to medication, or any number of other reasons. There is room in our healthcare system for both.

So there are 32 more RRTs working in primary care now than there were eight years ago. It's not a large number, but it's a good start. With our expert technical knowledge and clinical skills, RRTs are well-positioned to make a major contribution to the evolution of primary care in Ontario, and the sky is the limit.

Your fellow RTs hard at work helping you!

The CRTO would like to thank the following Members for the valuable assistance they have provided the CRTO over the past few months. We are very grateful for the contribution to the CRTO that the professional insight of these RT Members has provided.

QA PORTfolio Reviewers

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Amy Massie
Angie Shaw
Susan O'Neil
Elizabeth Cochrane
Janet Fraser

RT Week Events

Carol-Ann Whalen
Rhonda Contant

IEHP Competency Assessment Working Group

Saira Butt
Allison Chadwick
Denise Murphy
Michelle Sinclair
Myron Steinmann

RTs Working with Non-Regulated Health Care Providers in the Community

Dave Jones, RRT

By Dave Jones, RRT

The professional diversity of the healthcare team in Canada is increasing, and this means that Registered Respiratory Therapists (RRTs) frequently work side-by-side with both regulated and non-regulated healthcare providers (HCP). Being that the ultimate goal is optimal patient care, it is essential that RRTs do everything possible to ensure that the healthcare team functions as safely and effectively as possible. This is true of all settings in which RTs provide their services to patients.

That being said, the challenges of working with non-regulated HCP in the community setting are somewhat different than in a hospital environment. For one, although there are plenty of opportunities to teach both paid and unpaid care providers, there is often little prospect in the community of being able to follow up to ensure the maintenance of their competencies over time. Also, in addition to Personal Support Workers (PSW) and Developmental Service Workers (DSW), there are a number of paid care providers who have no specific credentials. These individuals have acquired their training on-the-job and the services that they may need to provide can range from oxygen administration to the care of ventilated clients; most commonly those individuals requiring non-invasive ventilation. RRTs working in the home care setting regularly instruct non-regulated HCPs on how and when to apply oxygen, as well as what factors to consider when adjusting oxygen flow. The home care RRTs must provide instruction on the progression of the underlying disease and how the mask and bi-level system is integrated into that. The training for non-regulated providers in the community involves such things as troubleshooting, mask fitting, the importance of client compliance and when to escalate concerns. Some of the biggest challenges that home care RRTs face in these situations are dealing with the highly variable backgrounds and prior knowledge of the care provider. In addition, it can take a significant amount of time to transfer the necessary amount of knowledge so that the non-regulated provider can function safely and effectively when the RRT is not present.

As the practice of Respiratory Therapy moves more and more into the community, RRTs will be called upon to strengthen and expand their capacity as collaborative care coordinators. The RRTs ability to share their broad knowledge with others outside of the walls of a hospital is vital now, and will become even more so in the future.

RRTs/CREs out in the Community

For over eight years, RRTs and Certified Respiratory Educators **Amy Massie** and **Angie Shaw** have provided a variety of community outreach services through the Robertson Centre for Airway Health (Airway Clinic) at St. Mary's General Hospital in Kitchener. St. Mary's is a Centre of Excellence for Respiratory and Thoracic Care and Amy and Angie contribute to the hospital's preeminent stature by providing asthma education, chronic obstructive pulmonary disease self-management, and smoking cessation counseling both at St. Mary's and at several off-site locations. One of their community programs is at Dr. Harold Kim's office-based Asthma Clinic. Dr. Kim is an Allergist and Clinical Immunologist and Amy and Angie spend one full day per month at his office seeing the patients he refers. Each visit entails pre and post bronchodilator spirometry, disease specific education, and inhaler technique, etc. After the patient education, the RT provides a full report to Dr. Kim that includes the patient's current level of asthma control, their spirometry results, as well as recommended areas for improvement. What makes this arrangement truly unique is that they have a joint visit with the patient and Dr. Kim. This partnership has been in effect for just over one year and has proven very successful.

Amy Massie, RRT and Dr. Harold Kim

Amy Massie RRT, CRE reports that "This is an excellent opportunity for patients to see not only their specialist, but an RT at the same time. Care gaps are avoided with this close relationship. Our documentation is embedded into Dr. Kim's electronic records, and a summary is sent to the patient's primary care physician".

Dr Kim MD, FRCPC states that …

> *"I have been very fortunate to be running an asthma clinic in our private clinic in Kitchener with Amy and Angie. The experience for our patients, staff and myself has been outstanding! The clinical assessments and suggestions from the CREs have led to asthmatics with very good asthma control, a better understanding of their condition and proper use of their medications. As well, the friendly interactions and solid professionalism demonstrated by the CREs has been greatly appreciated by our patients. We will be recommending this approach to asthma education to our colleagues across the country."*

Harold Kim MD, FRCPC ~ Allergist and Clinical Immunologist, Kitchener; Adjunct Professor of Medicine, Western University; Assistant Clinical Professor, McMaster University, Hamilton. Past President of the Canadian Network for Respiratory Care.

Respiratory Home Care, Challenging Community Care

Susan O'Neil, RRT

By Susan O'Neil, RRT

Over the last 20 years, we have seen a significant evolution in the delivery of home respiratory care. Gone are the days when an otherwise stable individual is discharged from hospital to home requiring little more than reassurance and a cylinder of oxygen and/or an aerosol compressor. Now every manner of high technology instrumentation is slowly making its way into the home on a long term basis. Home care RRTs often deal with situations that are very similar to a hospital room set up in the home. Not only is more critical care equipment and technology making its way into the community, but clients with more complex medical considerations than before want to be more active and mobile outside of the home.

The progression of the profession of respiratory therapy has led to the Home Care RRTs dealing with a wide variety of situations never before dealt with in a community setting. As more and more client services move from acute and chronic care facilities into the home, the RRTs who work in Home Care must rely on all the hard skills initially learned in school and developed through a professional career to be capable of providing traditionally "hospital" respiratory services in the home (e.g., invasive and non-invasive mechanical ventilation, secretion clearance and medication administration).

There is now a plethora of respiratory therapy equipment available for home care that was not available or even considered when I began practicing (e.g., BiLevel PAP, AutoPAP, Average Volume Assured Pressure Support (AVAPS), etc.). The changes in the delivery of CPAP therapy and improvements in the size and noise level of the units, as well as the improvements in selections and sizes of interfaces (e.g., for PAP delivery), is phenomenal. At least every two years there has been a steady improvement or major redesign in the components for PAP delivery. In addition, now clients often have their PAP therapy monitored remotely.

This means that the Home Care RRT must maintain a level of currency with the technological and medical advances that continue to have an enormous impact on community care. Clients that years ago would never have been

Respiratory Home Care, Challenging Community Care

considered for discharge are routinely sent home, and far sooner than ever before. These clients often have complex medical issues and therefore, the Home Care RRT must have the skills to recognize and deal with their care and safety needs. Not only does a Home Care RRT need excellent clinical judgement to ensure the delivery of safe and appropriate care to their client, but they also must use good judgement in appreciating and understanding human behaviour and cultural diversity to maintain the flexibility in thinking required to select the appropriate care plan.

As health care delivery continues to be scrutinized it becomes more important for home care RRT's to contribute to the continuity of care from hospital to home as never before. Here they can play a key role and partner in new ways with health care facilities, agencies and other health care professionals (HCP). Home Care RTs have much to offer this paradigm shift in health care as they continue to expand their roles and contribute to the more cost effective delivery of quality health care.

The unique situations encountered in home care may go unappreciated by other colleagues. Not only will Home Care RRTs benefit their patients from their own continuing education and professional development, they can offer much to the continuing education and professional development of the hospital HCP as well. Professional development and learning will continue to be pivotal to providing excellent care for all.

Some solutions to our challenges are available through on-line learning and partnering community, hospital and home care providers in courses on different competencies and expanding clinical rotations through providers in both hospital and home care. Home care Respiratory Therapists have a leadership role in the inter-professional collaboration of Respiratory Services in the home.

How do I find oxygen outside of the hospital?

Dave Jones, RRT

By Dave Jones, RRT

The need for home oxygen is identified in many different places in our healthcare system. Many people are started on oxygen during a hospital admission, but cannot be weaned from it prior to discharge home. People may be assessed in an outpatient clinic, at their family doctor, at a specialist appointment, at an appointment with their family health team, in their home by the palliative care team and through many other avenues. In many cases the Respiratory Therapist is asked to see a person in their home to assess the need for oxygen therapy. In the end, eligibility for home oxygen in Ontario is predicted by funding eligibility in most circumstances. There are several health care professionals that can order oxygen, but most funding agencies will only accept the prescription of a medical doctor.

The primary funding agency in Ontario is the Ministry of Health and Long-Term Care via the Home Oxygen Program (HOP) of the Assistive Devices Program. The vast majority of people requiring oxygen in Ontario are funded through this program. The criteria for funding people is reasonably clear, adults that require oxygen at home are required to have a room air arterial blood gas drawn in a hospital or laboratory that presents a PaO2 <55mmHg. There are a few exceptions that allow the PaO2 to be 55-60mmHg, but I won't recite the entire HOP manual. There is also an allocation for situations where ABG's cannot be drawn which requires a letter of explanation from the prescribing physician. This ABG result in conjunction with a diagnosis supporting the need for oxygen and the prescribing physician's signature qualify the person to receive oxygen in his/her home. People that are at the palliative stage of life can be funded for oxygen without the ABG requirement. This funding requires the same prescription, but is designed for people at the very end–stage of life as it only provides coverage for 90 days and is only accessible once in a lifetime. Children under 18 are also not subject to the ABG requirement, but must have printed oximetry results showing at least two minutes of SpO2 <88%. There is even a funding process for people that only demonstrate desaturation with exertion. The funding eligibility has to be requalified with oximetry at 90 days and annually for most people receiving oxygen. There are many other nuances to the funding through the HOP so it is advisable to speak with a Respiratory Therapist at your local home respiratory company to confirm someone's eligibility.

There are many other funding agencies serving other people including third party insurance, Blue Cross, NIHB, hospital/ LHIN programs and others. Many of the funding criteria align with HOP, but there are circumstances where the funding criteria may be more liberal. Options are worth investigating if you feel that there is clinical benefit.

The need and application of home oxygen continues to evolve and the process to receive oxygen may change as our healthcare model changes. As always, this is an interesting time to be involved in community care.

The "RT Difference" in the Home from the Patient's Perspective

By Carole Hamp, RRT, Manager, Quality Practice
(Guidance provided by Janet Fraser, RRT, Staff Therapist at West Park Healthcare Centre)

Janet Fraser, RRT

The following are some scenarios written from the perspective of patients who have received the services of an RT in the community.

- I have recently been sent home from the hospital on what they tell me is a "BiPAP" device that uses a mask that covers both my mouth and my nose. I was finding it very difficult to get used to this big mask and then a friend came over who has a "CPAP system" with a little pillow that just go in her nose. My friend wanted to know why I had to use such a big mask, and this made me very uneasy because I didn't have an answer for her. Also, I was worried that I wouldn't be able to use the BiPAP because I have been given the wrong mask. So I called the hospital and was given one of the RTs to speak to. She explained to me that my situation was very different from my friend's and therefore, the big mask was the best one for me. I know it seems like such a simple thing, but I felt much better after I spoke to the RT. She was able to explain everything so clearly, and it was good to know I could call her if I had any questions.

- I have COPD and I live at home with my wife, who I have been married to for almost 60 years. I need to wear oxygen all the time but it usually doesn't slow me down too much. However, a while back I had not been feeling well for a few days, but I didn't want to bother my wife about it because she worries about me enough as it is. Just around that time, the RT who looks after my oxygen came by for one of his regular visits and he listened to my chest. He said my lungs were not getting much air in and out of them, and he suggested that I go to the hospital right away. It was very reassuring to have someone right in my home who knows what they're talking about and can give me directions as to what to do. I am sure I would have gotten much sicker before going to the hospital without the RTs help.

- I had an issue recently where having access to an RT in my home made a very big difference in my life. I have ALS and have been living at home with a trach on a ventilator for about 6 years now. A little while back I felt that something just wasn't right, and at first I thought there was a problem with my ventilator. I just didn't feel I was getting a full breath, and you can just imagine what that feels like 24/7. Turns out my trach tube was not

The "RT Difference" in the Home from the Patient's Perspective

staying properly inflated. So I called the RT who normally comes to my home to do regular trach changes and told him about the problem. He was able to reschedule the regular trach change date so that he could come immediately, and he performed a trach change right then and there. This saved me 2 ambulance rides and hours in the Emergency room waiting to see a doctor.

- My wife is not very old but has been ill for some time now. Her disease causes her muscles to get weaker and weaker; so much so that she even has trouble clearing her own secretions. We recently approached the respirologist at our local hospital, and he referred us an RT for breath stacking and assisted coughing lessons. The RT helped us get the equipment we needed to manage on our own, and at a very reasonable price. She was able to coach my wife and I on techniques to clear the secretions without resorting to a lot of painful suctioning.

- Our son is a young man with advanced Duchenne Muscular Dystrophy. His disease has progressed to the point where he is now in the hospital on a ventilator with a trach, and this meant that for a time he could no longer speak. It was the RTs in the intensive care unit who worked with him for several weeks getting him used to deflating the cuff, then using a speaking valve. Our son was so grateful to get his voice back.

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/members/professional-development/upcoming-professional-events/.

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

The 5th Authorized Act Administering a Prescribed Substance by Inhalation

The Impact of Respiratory Therapy Practice

There are a lot of steps that need to be taken to go from simply thinking about adding an authorized act, to making that act a part of Respiratory Therapy (RT) practice. Below is a summary of the steps that the CRTO and its stakeholders took towards making the new 5th controlled act (administering a substance by inhalation) a reality.

2008

In response to the Health Professions Regulatory Advisory Council's (HPRAC's) review of non-physician prescribing, the CRTO submitted a proposal requesting that its Members be permitted to independently prescribe/order oxygen.

2009

HPRAC makes its recommendations to the Ministry of Health and Long-Term Care (MOHLTC) and the *Respiratory Therapy Act, 1991* (RTA) is amended to include a 5th authorized act "*administering a prescribed substance by inhalation*".

2010 - 2011

CRTO develops and submits its proposal for new *Prescribed Procedures Regulation* to the MOHLTC that lists oxygen as a substance that RTs can administer without the requirement of an order. (The regulation was approved Nov. 2012).

2012

At the request of MOHLTC's Assistive Devices Program's (ADP) Home Oxygen Program, the CRTO submits a proposed new *Conflict of Interest Regulation* (approved Sept. 2013). ADP also recommends that the CRTO develop a best practice guideline on oxygen administration.

2011 - 2013

The CRTO Professional Practice Committee develops an *Oxygen Therapy Clinical Best Practice Guideline*, which is circulated to the Membership for feedback (March - May 2013) and is then approved by Council (Sept. 2013).

The 5th Authorized Act Administering a Prescribed Substance by Inhalation

Why add administering a substance by inhalation? Don't we already do that?

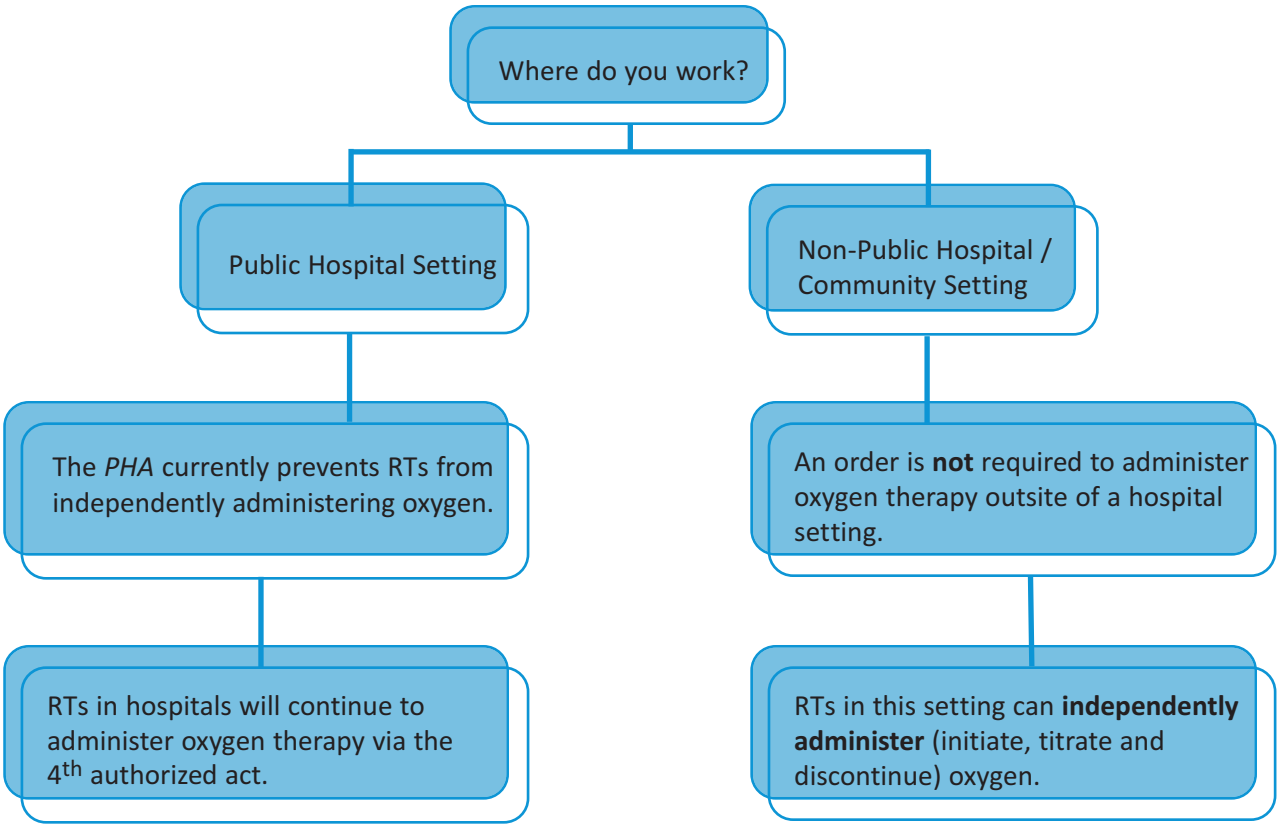
RTs can indeed administer a substance by injection or inhalation, such as pressurized gases and bronchodilators, under the 4th authorized act in the RTA. However, that act requires an order from a physician, midwife, dentist or nurse practitioner. The 5th authorized act is different because it does not carry with it the requirement of an order; just as the 2nd authorized act (*suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx*) does not require an order.

You will note that the 5th authorized act is also worded a bit differently than the 4th act. The 5th authorized act is administering a prescribed substance by inhalation, which in this case means "prescribed in regulation". As you saw in the previous diagram, the *Prescribed Substances Regulation* currently lists oxygen as the prescribed substance that RTs can administer.

So what does it all mean?

Well, for right now anyway, the answer to that depends on where you work, because there is legislation that restricts what healthcare practitioners can do in certain settings. The most applicable piece of legislation in this instance is the *Public Hospitals Act* (PHA), which stipulates that every act performed in a public hospital requires an order, and it limits who can provide those orders. **However, this restriction does not apply to non-public hospital/community practice settings (e.g., Home Care, Family Health Teams, private community-based clinics, etc.).** Please follow the flow diagram on the next page to see how the 5th authorized act impacts your practice.

The 5th Authorized Act
Administering a Prescribed Substance by Inhalation



What does "independently administer" mean?

"Independently" means that an RT who holds a general certificate of registration (without any terms, conditions or limitations (TCL) restricting them from performing this act) can administer oxygen in a non-public hospital/community setting without an order from a physician, midwife, dentist or nurse practitioner. "Administer" means the initiation, titration and discontinuation of oxygen.

Key Considerations...

- Members need to be aware of any facility/agency standards or protocols that might exist that would affect their authority to perform the 5th act.
- Other pieces of legislation (such as the *Regulated Health Professions Act* (RHPA) and the RTA), as well as certain regulations (such as the *Professional Misconduct Regulation* and the new *Conflict of Interest Regulation*), govern RTs practice in all settings.

If you wish further information, please contact **Carole Hamp RRT – Manager, Quality Practice** at hamp@crto.on.ca or at 1-800-261-0528 x33.

Test Your Knowledge

This "test your knowledge" is based on the special RT Week *e*-bulletin.

1. A parent of a child that an RT sees frequently in an outpatient Asthma Clinic has sent the RT a "friend request" on Facebook™. The RT accepts the request and comments on the parent's recent vacation photos. This is an acceptable course of action.

    a) True, because the parent is not the RT's patient and the Facebook interaction takes place when the RT is not at work.

    b) False, because the online personal relationship blurs the professional boundaries that exist between the RT, her patient and the patient's family.

To view the most recent installment of Elevating the Profession, which is entitled, Enriching knowledge: Enhancing professionalism: Cyber Safety, please refer to the RT Week *e*-bulletin.

For more information on Pause Before you Post *e*-learning module please click on the following link: www.crto.on.ca/members/professional-development/%E2%80%A2-e-learning/

2. A child with suspicious bruising presents in an emergency department and is treated by an RT, nurse and physician. The doctor and nurse discuss the situation and decide that they may or may not make a report to the Children's Aid Society (CAS) at a later date. What should the RT do?

    a) Inform the doctor that it is the most responsible physician who must immediately inform the CAS if child abuse is suspected.

    b) Make a report immediately and directly to the CAS, because it is not acceptable to wait or to rely on anyone else to make the report.

    c) Observe the child and the parents together, and wait until there is more evidence of abuse before making a report the CAS.

For the Prevention of Abuse of Patients/Clients Professional Practice Guideline, please click on the following link: www.crto.on.ca/pdf/PPG/abuse.pdf (p. 9 - 10).

Test Your Knowledge

3. What was the purpose of developing a Professional Practice Guideline on Oxygen Therapy?

    a) To provide Members who work in hospitals with the additional training they might need to practice in a home care setting.

    b) To ensure that all RTs, regardless of where they work or where they attended school, know how to properly administer oxygen.

    c) To set a provincial standard for oxygen therapy that will help guide policy and procedure development for our profession, as well as other healthcare providers.

For more information, please refer to the September Council Meeting Highlights in the RT Week *e*-bulletin.

4. What new method of communication did the CRTO start using during RT Week?

    a) Twitter™

    b) Facebook™

    c) LinkedIn™

Disclosure of Information

Practice FAQ

Question

An adult patient was brought into our emergency department by police and subsequently required intubation. During the intubation, the police officers overheard me say to one of the nurses that the patient smelled of alcohol. The officer approached me later to ask if I thought the patient had been drinking. What information am I able to disclose about a patient to a police officer?

Answer

The CRTO *Professional Misconduct Regulation* states that it may be considered to be an act of professional misconduct for a Member to be:

> *Giving information about a patient or client to a person other than the patient or client or his or her authorized representative except with the consent of the patient or client or his or her authorized representative or as required by law.*

"Required by law" refers to situations that fall under relevant statutes, such as the *Child and Family Services Act* (CFSA), which outlines the requirement to report if any person has reasonable grounds to suspect that a child has suffered, or is likely to suffer, physical, sexual or emotional harm [s. 71(1)]. The CFSA goes on to state that a person must report directly to the Children's Aid Society and "*shall not rely on any other person to report on his or her behalf*" [s. 22 (1)].

"Required by law" also refers to situations where an RRT is served with a summons or subpoena, however, it does not apply to speaking with a police officer who is doing an investigation. In this situation, the CRTO would advise the RRT to politely tell the police officer that confidentiality precludes him or her from speaking about the patient. The RRT may suggest that if the officer were to issue a subpoena for the RRT to attend in court that would be enough to allow the RT to disclose what they observed. That way, the police officer will understand that the RRT wishes to assist with any necessary investigation, but that they must balance that with their obligation to the patient.

"The best part of self-regulation is the opportunity to become involved and really make a difference in my profession." ***- CRTO Member***

The CRTO is in need of Members to help develop and/or review important College programs. If you would like to be part of the future of your profession and can spare *anywhere from a few hours to a few days* during the year please fill out the form below and fax it to the College at (416) 591-7890.

Surname	Given Name	CRTO No.
Address		
City	Province	Postal Code
Telephone	Email	
General area of practice/interest		

I am interested in the following areas (check all that apply):

Quality Assurance Program
- PORTfolio Reviewer
- Professional Standards Assessment Item Reviewer
- Professional Standards Assessment Item Writer

Professional Practice
- Practice Guideline Working Group
- Standards Review Working Group

Focus Groups

Piloting New Initiatives

Thank you in advance for your interest! We will be in touch.

Registration Changes

March 1 to August 31, 2013

New Members

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

General Certificates of Registration (RRT) Issued:

ALI, Ummaima
AURICCHIO, Randi
BISWAS, Kheya
BOLOGNA, Angela
BOULAY, Courtney
BUHR, Michael
BUTT, Saira
CAILLE, Melissa
CAMPBELL, Tracy
CARSON, Elizabeth
CHAKRABARTI, Anita
CHAMPAIGNE, Danielle
CHARKAVI, Phillip
CHRISTNER, Andrew
CLEVERSEY, Byron
COMEAU. Andrée-Michèle
CORIN, Mandy
COUTU, Nicole
CROTHERS, Jenna
DE VEYRA, Cathrine
DEBOUTER, Angela
DOBRACA, Kasim
DUONG, Jenny
EARLE, Katelyn
ESHGHI, Sara
FERNANDEZ, Marry
FERRIGAN, Mandee
FOROUZANDEH, Seema
GARCIA, Angela
GAUDIO, Dominic
GAUTHIER, Isabelle
GIBSON, Jason
GIBSON, Stacey
GODFREY, Breen
GOURE, Marcel
GUBBELS, Jordan
HARRIS, Whitney
HEWITT, Kimberley
HUGHES, Danielle
HUI, Clement
ILIC, Sanela
JANKOWSKI, Caroline
JENNINGS, David
KARGANILLA, Oliver
KEIM, Nicholas
KING, Jaclyn
KNOWLTON, Meagan
LAM, Yee
LAMARCHE, Shane
LANCASTER, Sherisse
LAPORTE, Francine
LAVOIE, Laura
LE, Marie
LEDUC, Amélie
LI, Tsz-Ho
LIU, Steven
MARCINKOWSKI, Jessica
MARKOWSKI, Paul
MATEEN, Khalid
MAUGERI, Lenneah
MEEK, Nadine
MISCAVISH, Lindsay
MORGAN, Alaina
ODISHO, Odisho
PAGE, Shawn
PASCOS, Nicholas
PELTON, Emily
PHAN, Mai
PRUNER, Amiko
RAHMAN, Sadaf
RAICEVIC, Carolyn
ROLDAN, Paul
ROSSITER, Jan
ROTOBILSKY, Kyla
SHANMUGHARAJAH, Keshigaa
SIDHU, Kiranjit
SIMARD, Genevieve
SIU, Nigel
STOCKWELL, Karen
STUART, Holly
SZOZDA, Dianne
TAN, Kenrick
TRAM, Tiffany
UDUMULLAGE, Thilanka
VITEK, Marina
WAHAJ, Ellaha
WAN, Pak
WARD, Emily
WASZAK, Caroline
WATSON, Megan
WISEMAN, Whitney

Graduate Certificates of Registration (GRT) Issued:

DE VERA, Anna Marie
JAMIESON, Elizabeth
LANDINGIN, Alyssa
MOORING, Jean
SARAIVA, Kevin
STAFFORD, Brian
TO, Tai
WU, Hin Cheung

Resigned

AIKEN, Stacy
BURNS, Paula
COOK, Robert
CURRIE, Kathleen
GILMORE, Corinne
JOHNSON, Kathy
KNIGHT, Carly
KWAN, Steve
MALONE, Melissa
MANN, Dale
MCLAUGHLIN, Sharon Anne
MILKS, Mike
NORTHCOTT, Jennifer Anne
POTHIER, Matthew
ROWETT, Marion
SNOWDON, Maxine
VALERIO, Ashley
VAUTOUR, Paulette
WESTERGAARD, Joan
WILSON, Jennie-Ann
WINDATT, Amanda

Suspended

ABUBAKAR, Warsame
AGARD, Donell
AHUJA, Neenu
BARNARD, Derek
BRIDGE, Cynthia
CZYZ, Patrycja
DALTON, Kerry
DOUGLAS, Karen
EL KOCHAIRI-ORTIZ, Luz
FETTES, Leigh
GABBAY, Rina
HUSSAINI, Munira
KIERYLO, Pawel
MALONE, Megan
MULLALY, Adam William
PAGE, Wendy CR
SCOTT, Tracy
SITKO, Emily
STILL, Joyce
TA, Quyen
TINANI, Naresh
TURCOTTE, Tara
WINKER, Abigail
WU, Zhengrong
YEAMAN, Sara
ZETTEL, David