CRTO

Council Meeting Materials

April 8, 2022

Zoom Video Conference
https://us02web.zoom.us/j/83681434632

Meeting ID: 836 8143 4632
Passcode: 148284

Find your local number: https://us02web.zoom.us/u/knYTg7qAk

College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

AGENDA ITEM # 2.0

0900 am to 1100 am
Zoom Video Conference

Time	Item	Agenda	Page No.	Speaker / Presenter	Action	Strategic Focus
	1.0	**Introduction**		Lindsay Martinek		
	2.0	**Approval of Council Agenda**		Lindsay Martinek	Decision	Governance & Accountability
	3.0	**Operational & Administrative Issues**				
	3.1	REVISED Conflict of Interest PPG – For Final Approval		Kelly Arndt	Decision	
	3.2	REVISED Responsibilities under Consent Legislation PPG – For Final Approval		Kelly Arndt	Decision	
	3.3	REVISED Oxygen Therapy CBPG – For Final Approval		Kelly Arndt	Decision	
	4.0	**Legislative and General Policy Issues**				
	4.1	REVISED Disclosure of Witness Statements Policy – For Final Approval		Kelly Muñoz	Decision	Core Business Practices
	4.2	REVISED Health Professions Appeal and Review Board Appeals for ICRC Policy – For Final Approval		Kelly Muñoz	Decision	Core Business Practices
	4.3	REVISED Entry-to-Practice Competency Assessment Policy – For Final Approval		Christa Krause	Decision	Core Business Practices
	4.4	REVISED Entry-to-Practice Competency Assessment Appeals Policy – For Final Approval		Christa Krause	Decision	Core Business Practices
	4.5	REVISED Labour Mobility: Applicants from Regulated Canadian Jurisdictions Policy – For Final Approval		Christa Krause	Decision	Core Business Practices
	4.6	REVISED Language Proficiency Requirements Policy – For Final Approval		Christa Krause	Decision	Core Business Practices
	4.7	REVISED Registration Currency Policy – For Final Approval		Christa Krause	Decision	Core Business Practices
	4.8	REVISED Professional Development Program Policy – For Final Approval		Ginette Greffe-Laliberté	Decision	Core Business Practices

4.9	Policies being Rescinded & Archived	Carole Hamp	Decision	Core Business Practices
5.0	**Other Business**			
6.0	**Next Meeting - Council: May 27, 2022**			
7.0	**Adjournment**			
	Open Forum			

Council Motion

AGENDA ITEM # 2.0

Motion Title:	*Approval of Council Agenda*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

The Council approve the *Council Meeting Agenda for April 8, 2022*. (A copy is attached to the materials of this meeting).

Council Briefing Note

AGENDA ITEM # 3.1 **April 8, 2022**

From:	*Kelly Arndt RRT, Quality Practice Coordinator*
Topic:	*Draft Revised Conflict of Interest (PPG)*
Purpose:	*For Decision*
Strategic Focus:	*Protecting public interest by ensuring that Respiratory Therapists understand their professional responsibilities and obligations with respect to conflicts of interest.*
Attachment(s):	Appendix A – Revised Conflict of Interest PPG Appendix B – Consultation Feedback Summary

PUBLIC INTEREST RATIONALE

The *Conflict of Interest Regulation*, which is within the *General Ontario Regulation* (O. Reg. 596/94) established under the *Respiratory Therapy Act*, *1991,* was approved in 2013. This Professional Practice Guideline (PPG) enables Respiratory Therapists (RTs) in Ontario to understand the expectations and professional responsibilities set out by the College of Respiratory Therapists of Ontario (CRTO) and this regulation regarding conflict of interest.

ISSUE:

Previously revised in June 2014, the Conflict of Interest PPG has been reviewed and updated. While mentioned in the CRTO's Standards of Practice 5, Conflict of Interest, this PPG sets out further direction for RTs, including definitions, identifying, and preventing conflict of interest.

BACKGROUND:

The patient/client and RT relationship is fiduciary (duty of loyalty, good faith, and diligence) in nature and is built on trust. This trust should not be undermined by a conflict of interest or even the perception of a conflict of interest. The *Conflict of Interest Regulation* clearly states that "*a **Member** shall not practice the profession while in a conflict of interest*", and practicing the profession while in a conflict of interest is considered to be professional misconduct. It is, therefore, extremely important that the expectations and guidelines for Members surrounding this topic are clear, current, and concise.

ANALYSIS:

Summary of Changes

The format of this document remains in its original version. A jurisdictional and regulatory scan was conducted to confirm that the content of the document is current and aligned with all relevant legislation and regulations. The content has been revised to include legislation amendments, gender neutral language and updated links and references. Addition made to the "Treatment of a Spouse" section.

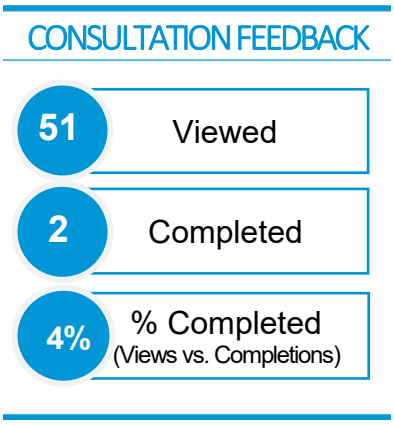
Public Consultation

The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website, tweeted on the CRTO Twitter account and shared with members in the December *e*bulletin. In total, 51 people viewed the consultation survey, and 2 responses were received.

There were no comments received. No changes were made to the Conflict of Interest PPG as a result of this feedback.

For full consultation results see appendix B.

Date consultation opened: December 13, 2021
Length of time consultation was open: 46-days
Date consultation closed: January 28, 2022



RECOMMENDATION:

It is recommended that the CRTO Council approve the revised Conflict of Interest PPG as per the attached motion.

NEXT STEPS:

If the Motion is approved, the PPG will be published to the website and circulated to CRTO Members.

Council Motion

AGENDA ITEM # 3.1

Motion Title:	*Revised Conflict of Interest Professional Practice Guideline (PPG)*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

Council approves the *Revised Conflict of Interest Professional Practice Guideline* (PPG) as presented. (A copy is attached as Appendix A to this motion within the materials of this meeting).

Appendix A: Conflict of Interest PPG

Revised Conflict of Interest Professional Practice Guideline (PPG). This PPG will also be available to members and the public as a mini website. Please click here if you wish to view. **Note:** this link is still private and will not be available to the public until April 14, 2022, when circulated in the April *e*bulletin.

Date Published: APRIL 2022
Document Number: PPG-130

CONFLICT OF INTEREST

PROFESSIONAL PRACTICE GUIDELINE

PROFESSIONAL PRACTICE GUIDELINE

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO (CRTO) PUBLICATIONS CONTAIN PRACTICE PARAMETERS AND STANDARDS SHOULD BE CONSIDERED BY ALL ONTARIO RESPIRATORY THERAPISTS IN THE CARE OF THEIR PATIENTS/CLIENTS AND IN THE PRACTICE OF THE PROFESSION. CRTO PUBLICATIONS ARE DEVELOPED IN CONSULTATION WITH PROFESSIONAL PRACTICE LEADERS AND DESCRIBE CURRENT PROFESSIONAL EXPECTATIONS. IT IS IMPORTANT TO NOTE THAT THESE CRTO PUBLICATIONS MAY BE USED BY THE CRTO OR OTHER BODIES IN DETERMINING WHETHER APPROPRIATE STANDARDS OF PRACTICE AND PROFESSIONAL RESPONSIBILITIES HAVE BEEN MAINTAINED.

RESOURCES AND REFERENCES ARE HYPERLINKED TO THE INTERNET FOR CONVENIENCE AND REFERENCED TO ENCOURAGE EXPLORATION OF INFORMATION RELATED TO INDIVIDUAL AREAS OF PRACTICE AND/OR INTERESTS. BOLDED TERMS ARE DEFINED IN THE GLOSSARY.

It is important to note if an employer's policies are more restrictive than the CRTO's expectations, the RT must abide by the employer's policies. Where an employer's policies are more permissive than the expectations of the CRTO, the RT must adhere to the expectations of the CRTO.

The CRTO will update and revise this document every five years, or earlier, if necessary. The words and phrases in bold lettering can be cross referenced in the Glossary at the end of the document.

CONTENTS

INTRODUCTION

An essential element of safe, competent, and ethical care requires Respiratory Therapists (RT) to place patient/client interest above their own personal and financial interests. The patient/client and RT **relationship** is **fiduciary** (duty of loyalty, good faith and diligence) in nature and is built on trust. This trust is very important and should not be undermined by a conflict of interest or even the perception of a conflict of interest.

The *Conflict of Interest regulation*, which is within the General Ontario Regulation (O. Reg. 596/94) established under the *Respiratory Therapy Act*, was approved in 2013. This regulation clearly states that "*a **Member** shall not practice the profession while in a conflict of interest*". Practicing the profession while in a conflict of interest is considered to be **professional misconduct** under the *Professional Misconduct regulation* (O. Reg. 753/93). Therefore, ideally RTs should not place themselves (or allow themselves to be placed) in any situation where there is an actual, potential or perceived conflict of interest. However, each scenario is unique and it is difficult to clearly define in advance every possible set of circumstances where a conflict of interest might exist. The intent of this Professional Practice Guideline (PPG) is, therefore, to provide Members with key factors to consider when determining if a conflict of interest is present, which they can then apply to their specific situation.

Note that words and phrases denoted by **bold** lettering are cross-referenced in the Glossary at the end of the document.

This guideline is divided into three (3) primary sections:

1. Definitions
2. Identifying a Conflict of Interest
3. Preventing a Conflict of Interest

DEFINITIONS

CONFLICT OF INTEREST

A conflict of interest exists when an RT is in a position where their professional judgement, or duty to their patient/client could be compromised, or could be perceived to be compromised, by a personal relationship, commercial interest or financial benefit. A conflict of interest may be actual, potential, or perceived.

Actual Conflict of Interest
means that something has happened to influence an RT's professional judgment during their practice.

Potential Conflict of Interest
occurs where a **reasonable person**, would conclude that an RT might fail to fulfil their professional obligation to act in the best interest of the client.

Perceived Conflict of Interest
is where a reasonable person may conclude that the RT's professional judgment has been improperly influenced, even if that is not actually the case.

BENEFIT

A benefit may be described as a financial or non-financial consideration that might directly or indirectly influence, or appear to influence, an RT's professional judgment and/or objectivity.

Financial Benefit
is considered a tangible conflict because it can be seen and measured (e.g., rebate, credit, gift, profit, business interests).

Non-Financial Benefit
may include a personal gain or advantage that may influence treatment decisions or clinical activities (e.g., a patient/client provides an RT with a letter of reference for research grant application).

FOR EXAMPLE:

Being offered a commission for every patient that is added to the company's roster.

A conflict of interest cannot be avoided by moving the benefit to a **related person** or a **related company**. In other words, in considering whether or not an actual, potential or perceived conflict of interest exists, an RT must acknowledge that benefits to a related person or a related company are also benefits to them.

INTERESTS
PERSONAL AND FINANCIAL

The *Conflict of Interest regulation* (O.Reg 596/94 s.2) states the following:

> *"A member is in a conflict of interest if the member's personal or financial interest, or the personal or financial interest of another person who is in a non-arm's length relationship with the member conflicts (actual), appears to conflict (perceived) or potentially conflicts (potential) with the member's professional or ethical duty to a patient or the exercise of the member's professional judgment."*

Personal Interest
(e.g.) status, employment, career advancement.

Financial Interest
(e.g.) monetary payment, a rebate, credit, discount or reimbursement for goods or services, a payment or reduction of a debt or financial obligation, a payment of a fee for consultation or other services, a loan, a present that is more than token in nature, a service at a reduced or no cost.

SCENARIO:
An equipment vendor offers a department four free registrations to an upcoming RT conference. The manager, who is an RT, raffles the registrations off to the staff.

WHAT DO YOU DO?
The individual staff RTs would not likely be in a conflict of interest, provided they do not have significant input into decisions made about which piece of equipment to purchase. However, in this scenario, there is a perceived conflict of interest on the part of the RT manager. Any reasonable person may conclude that the manager's professional judgment has been improperly influenced by the "gift". Even if they did not have any input into equipment procurement decisions, there is a significant likelihood of the manager influencing the person who makes those decisions.

NON-ARM'S LENGTH RELATIONSHIP

People who are related to one another or joined in a business relationship are considered to be in a "non-arm's length relationship". This is because there is the potential for them to have undue influence over one another, and this may have an impact on their actions.

IDENTIFYING
A CONFLICT OF INTEREST

The *Conflict of Interest regulation* (O. Reg. 596/94) outlines the situations in which an RT might find themselves in an actual, potential or perceived conflict of interest [s. 3 (1)]. The likelihood of a conflict of interest increases when:

- The magnitude of the benefit is substantial (e.g., a full course meal with drinks at an expensive restaurant vs. muffins & coffee);
- The benefit is personal (e.g., a cash donation given to a specific individual vs. the entire RT department);
- There is no educational component (e.g., a department being offered lunch during RT week without any educational session vs. a lunch & learn); and
- It involves a patient/client (or their family) where there is an ongoing professional relationship (e.g., a current home care patient/client offers their RT a piece of antique china vs. the family of a deceased patient/client offering the same gift in gratitude for the RT's past services).

THREE KEY FACTORS TO CONSIDER WHEN IDENTIFYING A CONFLICT OF INTEREST

1. Why is this benefit being offered to me? (i.e., what advantage does this transaction provide to the person/organization proposing the benefit?)

2. Are there factors in this situation that influence, or might influence, my professional judgement and/or objectivity?;

SCENARIO:

An RT working in an asthma clinic has been approached by the owner of a local health food store to see if they would consider offering a line of herbal asthma remedies in their clinic. The RT believes that these products would be beneficial to some of their patients/clients and, in addition, the RT would also receive a percentage of the profit from the sales.

WHAT SHOULD YOU DO?

There are several issues involved with the above scenario. The first deals with the fact that such an arrangement clearly places the RT in a conflict of interest and should not be undertaken. The other concern is that the use of these herbal products is not likely part of the current medically accepted guidelines for the treatment of asthma.

3. Is it possible that others might perceive that my professional judgement and/or objectivity is impaired?

SCENARIO:

An RT has been asked by the family of a patient/client in the pulmonary rehab clinic where they work if they can sublet the RT's apartment while they are travelling during the summer.

WHAT SHOULD YOU DO?

This could be a conflict of interest as it may alter how the RT provides care to the patient/client in the future because the relationship is no longer purely professional in nature.

ADDITIONAL CONSIDERATIONS

1. Is my **relationship** with this patient/client purely professional?

SCENARIO:

An RT works both for a home care company and the local hospital. While working at a hospital, they are required to arrange home oxygen for a patient/client who wants to be set up with one particular company. However, it is the RT's professional opinion that the patient/client would receive better services if they went with the one that the RT works for.

WHAT SHOULD YOU DO?

Whether this is an actual or potential conflict of interest situation depends on if the RT will benefit in any way from adding this patient/client to their home care company's roster. Also, there is a chance that the patient may perceive this to be a conflict once they find out that the RT works for the company they are recommending. The best way for the RT to deal with this is to declare their relationship with the home care company up front.

2. Have I (or do I plan to) offer or receive a benefit (financial or non-financial) related to the referral of this patient/client to my practice or to the services that I provide?

3. Have I (or do I plan to) enter into an **agreement** (including related to my employment) that influences/appears to influence my professional judgement?

FOR EXAMPLE:

The RT Manager of a Sleep Lab enters into an exclusive service agreement with the manufacturer of a particular CPAP device because they are able to offer an incentive that the other companies cannot.

SCENARIO:

An RT owns a sleep lab and rents some of the office space to a home care company. The RT receives a percentage of the profits of the home care company; meaning that the more patients/clients the RT sends to the home care company, the greater their share.

WHAT SHOULD YOU DO?

To avoid a conflict of interest in this situation, the RT must disclose the income sharing arrangement to their patients/clients in advance of any referral to the home care company, and ensure them that their care will not be affected if they choose another company.

4. Have I (or do I plan to) engage in any form of revenue, fee or income sharing agreement that influences/appears to influence my professional judgement (O. reg. 596/94) s. 3(1)(g))?

TREATMENT OF A SPOUSE*

The sexual abuse provision in the *Regulated Health Professions Act (RHPA)* [Schedule 2 s. 1(3)] prohibits healthcare professionals from treating their spouses in a professional capacity. In the *RHPA*, sexual abuse is defined by an action, not by the intent. In addition, under the *RHPA*'s definition of sexual abuse, only a patient can be sexually abused. As such, regulated health professionals who provide treatment to their spouse, which then makes them their patient, fall within this definition. In other words, if a health professional is found to be treating their spouse (with whom they inherently have established a sexual relationship) they too would be subject to the mandatory revocation provisions of the *RHPA*. **Therefore, a CRTO Member must not provide respiratory therapy services to their spouse.**

* "spouse", in relation to a Member, has been defined in the *RHPA* as:

(a) a person who is the member's spouse as defined in section 1 of the Family Law Act, or

(b) a person who has lived with the member in a conjugal relationship outside of marriage continuously for a period of not less than three years.

Treating a sexual partner who does not meet the definition of a spouse under the RHPA will continue to be considered sexual abuse.

In addition, it is the view of the CRTO that RTs should avoid treating other family members as well. In providing treatment to a family member who is not a spouse, the Member risks not only being in an actual, potential or perceived conflict of interest, but they also risk a lack of objectivity that may affect their professional judgement. However, the CRTO recognizes that there may be circumstances where the RT is the only practitioner available to provide the necessary care, as is the case in sole-charge practice settings. In situations where it is in the patient's best interest for the RT to treat a family member who is not their spouse, this may be permissible until such time as alternative care arrangements can be made. Emergency care of family members where no one else is available is acceptable because the benefits outweigh the "challenges posed by the personal relationship". In such circumstances, the RT is encouraged to transfer care to an appropriate provider as soon as possible.

For more information on what constitutes sexual abuse, please see the CRTO's Abuse Awareness & Prevention PPG.

PREVENTING
A CONFLICT OF INTEREST

RTs should avoid any situation that may result in real, potential or perceived conflicts of interest. The *Conflict of Interest regulation* states that an RT is not considered to be in a conflict of interest related to a recommendation for a referral or treatment provided that the RT:

- Discloses the nature of the relationship or benefit to the patient/client; and
- Where applicable, advises the patient/client that their selection of supplier of a product or service will not adversely affect the assessment, care or treatment that they receive. (O. reg. 596/94). s. 4 (1) & (2).

It is also advisable that the RT:

- Provide the patient with information on at least one other source of the product(s) or service(s) required; and
- Documents any discussions with patient related to conflict of interest in the patient's record (e.g., documentation of full disclosure).

ILLUSTRATIONS OF
WHERE A CONFLICT OF INTEREST IS UNLIKELY

1. An RT offering or availing themself of a hospitality suite or hospitality food and beverage that a broad group of individuals have unrestricted access to.

2. Soliciting, offering, or accepting pens, paper or other reasonable or incidental items or gifts of a promotional nature at a conference.

3. Soliciting, offering, or accepting entertainment or hospitality that is not related to any exercise of professional judgment as a respiratory therapist (e.g. a vendor of respiratory therapy equipment offers you tickets to an entertainment event and you are not in a position, or perceived to be in a position, to influence the purchase of equipment).

4. Accepting reasonable, usual and customary hospitality (e.g. attending a holiday party given by a company).

5. Referring a patient/client to a home care company that has an agreement with the RTs hospital but that offers no direct benefit to the RT*.

PLEASE NOTE...

Even in situations where the RT does not receive a benefit, there remains a professional obligation to put the interest of the patient/client above any personal or organizational interests.

SCENARIO:

A staff RT works for a hospital that has a revenue sharing agreement with a respiratory home care company that maintains an office in the building. While they have not stated it outright, the hospital's management team has implied that they would like the RTs to encourage patients/clients to use this particular company.

WHAT SHOULD YOU DO?

It is the RTs responsibility to protect the interest of their patients/clients, and not allow themselves to be placed in a conflict of interest situation. Therefore, it is advisable to have a process in place that requires the RTs to disclose the hospital's relationship with that particular home care company and allow the patients/clients to choose another company if they wish. The patient/client must also be assured that the care that they receive will be in no way impacted by their decision to employ the services of a different home care company.

A FINAL WORD

Given their professional knowledge and position of authority, RTs are accountable for identifying, preventing and managing conflict of interest situations. It is important to note that consent on the part of a patient/client is not a defence in a conflict of interest situation.

The CRTO recommends that if an RT is in doubt about whether a conflict of interest situation exists, it is best to err on the side of caution. Although the CRTO can provide guidance regarding conflicts of interest, the individual Respiratory Therapist is responsible at the time to determine if an actual, potential or perceived conflict of interest situation exists. If anyone believes that an RT is in a conflict of interest, that person may submit a complaint to the CRTO.

GLOSSARY

Agreement a revenue, fee or income sharing arrangement.

Fiduciary a relationship based on trust and confidence

Member refers to a Respiratory Therapist (RT) who is registered with the CRTO as either a Registered Respiratory Therapists (RRT), Practical (limited) Respiratory Therapist (PRT) or Graduate Respiratory Therapists (GRT).

Professional Misconduct as defined in the *Professional Misconduct Regulation* (O. Reg. 753/93), which was established under the *Respiratory Therapy Act*.

Reasonable Person an individual who is neutral and informed

Relationship in the course of their practice, RTs engage in therapeutic (patient/client) and professional relationships (students, colleagues, coworkers).

Related Person means any person connected with a member by blood relationship, marriage, common-law or adoption, and

- persons are connected by blood relationship if one is the child or other descendant of the other or one is the brother or sister of the other;
- persons are connected by marriage if one is married to the other or to a person who is connected by blood relationship to the other;
- persons are connected by common-law if the persons have, for a period of not less than three years, cohabited in a relationship of some permanence; and
- persons are connected by adoption if one has been adopted, either legally or in fact, as the child of the other or as the child of a person who is so connected by blood relationship.

Related Company means a company, corporation or business partnership or entity that is owned or controlled, in whole or in part, directly or indirectly, by a person or another person related to the person.

REFERENCES

College of Nurses of Ontario. *Professional Conduct. (2019)* Retrieved from: https://www.cno.org/globalassets/docs/ih/42007_misconduct.pdf

College of Physicians and Surgeons of Ontario. *Physicians' Relationship with Industry: Practice, Education and Research. (2014)* Retrieved from: https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Physicians-Relationships-with-Industry-Practice

General, O. Reg 596/94. Retrieved on October 10, 2021 from: https://canlii.ca/t/527jh

Institute of Medicine (US) Committee on Conflict of Interest in Medical Research, Education, and Practice; Lo B, Field MJ, editors. *Conflict of Interest in Medical Research, Education, and Practice*. Washington (DC): National Academies Press (US); 2009. Summary. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK22926

College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

This Professional Practice Guideline will be updated as new evidence emerges or as practice evolves. Comments on this guideline are welcome and should be addressed to:

College of Respiratory Therapists of Ontario
180 Dundas Street West, Suite 2103
Toronto, Ontario
M5G 1Z8

Tel	(416) 591 7800	Toll Free	1-800-261-0528
Fax	(416) 591-7890	Email	questions@crto.on.ca

Appendix B: Conflict of Interest PPG Consultation Survey Results

Answers to Questions
Draft Conflict of Interest PPG Consultation 2021
As of: 3/1/2022 2:12:02 PM

Page: About You

Question: Are you a...

Respiratory Therapist (including retired)	2	67 %
Student of a Respiratory Therapy Program	1	33 %

Question: I live in...

Ontario	3	100 %

Page: Questions

Question: Is the purpose of the Conflict of Interest PPG clear?

Yes	No
2	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Do you agree that the Conflict of Interest PPG is clear and understandable?

Yes	No
2	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Is the Conflict of Interest PPG free from omissions and/or errors?

Number Who Answered: 2

Yes	No
2	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Does this Conflict of Interest PPG provide you with sufficient understanding of the expectations?

Number Who Answered: 2

Yes	No
2	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?

Number Who Answered: 0

Council Briefing Note

AGENDA ITEM # 3.2 **April 8, 2022**

From:	*Kelly Arndt RRT, Manager, Quality Practice*
Topic:	*Draft Revised Responsibilities Under Consent Legislation (PPG)*
Purpose:	*For Decision*
Strategic Focus:	*Protecting patient safety by ensuring that Respiratory Therapists understand their professional responsibilities and obligations under consent legislation.*
Attachment(s):	Appendix A – Revised Responsibilities Under Consent Legislation PPG Appendix B – Consultation Feedback Summary

PUBLIC INTEREST RATIONALE:

This Professional Practice Guideline (PPG) enables Respiratory Therapists (RTs) in Ontario to understand the expectations and professional responsibilities under consent legislation.

ISSUE:

Previously revised in February 2014, the Responsibilities Under Consent Legislation PPG has been reviewed and updated. While mentioned in the CRTO's Standards of Practice 6, Consent, this PPG sets out further direction for RTs in all aspects of types of consent, capacity, substitute decision making, and special considerations.

BACKGROUND:

This PPG provides an overview of legislation, specifically the *Health Care Consent Act (HCCA*) and the *Substitute Decision Act (SDA)* for RTs. It is extremely important that the expectations and guidelines for Members surrounding this topic are clear, current, and concise.

ANALYSIS:

Summary of Changes

The format of this document remains in its original version. A jurisdictional and regulatory scan was conducted to confirm that the content of the document is current and aligned with all

relevant legislation and regulations. The content has been revised to include current legislation, gender neutral language and updated links and references.

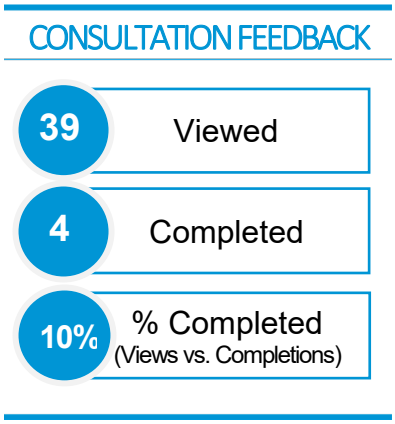
Public Consultation

The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website, tweeted on the CRTO Twitter account and shared with members in the December *e*bulletin. In total, 39 people viewed the consultation survey, and 4 responses were received.

There were no comments received. No changes were made to the Responsibilities Under Consent Legislation PPG as a result of this feedback.

For full consultation results see appendix B.

Date consultation opened: December 13, 2021
Length of time consultation was open: 46-days
Date consultation closed: January 28, 2022



RECOMMENDATION:

It is recommended that the CRTO Council approve the revised Responsibilities Under Consent Legislation PPG as per the attached motion.

NEXT STEPS:

If the Motion is approved, the PPG will be published to the website and circulated to CRTO Members.

Council Motion

AGENDA ITEM # 3.2

Motion Title:	*Revised Responsibilities Under Consent Legislation Professional Practice Guideline (PPG)*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

Council approves the *Revised Responsibilities Under Consent Legislation Professional Practice Guideline* (PPG) as presented. (A copy is attached as Appendix A to this motion within the materials of this meeting).

Appendix A: Responsibilities Under Consent Legislation PPG

Revised Responsibilities Under Consent Legislation Professional Practice Guideline (PPG). This PPG will also be available to members and the public as a mini website. Please click here if you wish to view. **Note:** this link is still private and will not be available to the public until April 14, 2022, when circulated in the April *e*bulletin.

Date Published: APRIL 2022
Document Number: PPG-180

RESPONSIBILITIES UNDER CONSENT LEGISLATION

PROFESSIONAL PRACTICE GUIDELINE

PROFESSIONAL PRACTICE GUIDELINE

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO (CRTO) PUBLICATIONS CONTAIN PRACTICE PARAMETERS AND STANDARDS SHOULD BE CONSIDERED BY ALL ONTARIO RESPIRATORY THERAPISTS IN THE CARE OF THEIR PATIENTS/CLIENTS AND IN THE PRACTICE OF THE PROFESSION. CRTO PUBLICATIONS ARE DEVELOPED IN CONSULTATION WITH PROFESSIONAL PRACTICE LEADERS AND DESCRIBE CURRENT PROFESSIONAL EXPECTATIONS. IT IS IMPORTANT TO NOTE THAT THESE CRTO PUBLICATIONS MAY BE USED BY THE CRTO OR OTHER BODIES IN DETERMINING WHETHER APPROPRIATE STANDARDS OF PRACTICE AND PROFESSIONAL RESPONSIBILITIES HAVE BEEN MAINTAINED.

RESOURCES AND REFERENCES ARE HYPERLINKED TO THE INTERNET FOR CONVENIENCE AND REFERENCED TO ENCOURAGE EXPLORATION OF INFORMATION RELATED TO INDIVIDUAL AREAS OF PRACTICE AND/OR INTERESTS. BOLDED TERMS ARE DEFINED IN THE GLOSSARY.

It is important to note if an employer's policies are more restrictive than the CRTO's expectations, the RT must abide by the employer's policies. Where an employer's policies are more permissive than the expectations of the CRTO, the RT must adhere to the expectations of the CRTO.

The CRTO will update and revise this document every five years, or earlier, if necessary. The words and phrases in bold lettering can be cross referenced in the Glossary at the end of the document.

CONTENTS

INTRODUCTION

The *Health Care Consent Act (HCCA)* and the *Substitute Decisions Act (SDA)* describe the legislative requirements for **Respiratory Therapists** (RTs) in regard to obtaining consent. The *HCCA* specifies that regulated health professionals are to follow their College's guidelines relating to obtaining consent and the provision of information to patients/clients who are found to be incapable.

The *HCCA* deals with obtaining consent in the following circumstances:

(i) for treatment,

(ii) for admission to a care facility and

(iii) for receiving personal assistance services.

In the context of respiratory therapy's scope of practice of, RTs are generally accountable for obtaining consent (or ensuring that consent has been obtained) from patients/clients regarding treatment.

ABOUT THIS DOCUMENT

Obtaining consent to treat a patient is embedded within the CRTO's Standards of Practice, in other words, it would be professional misconduct to proceed to treat a patient without consent. The **CRTO's** Standards of Practice and A Commitment to Ethical Practice documents provide further guidance to RTs surrounding their obligation and accountability in obtaining consent. This Professional Practice Guideline (PPG) provides an overview of the legislation, specifically the *HCCA* and *SDA* for RTs. The information is structured to first describe how to obtain consent for treatment from a capable person, and then how to proceed with obtaining consent for an **incapable** person. The key terms in **bold** are defined in the Glossary.

Obtaining consent can be guided by a step-by-step process that RTs should consider each time they are faced with obtaining consent for treatment. A decision tree is included as a visual aid below to assist RTs in their process of obtaining consent and to complement the outline of the PPG. RTs must remember to act within their scope of practice and use their professional judgement to always advocate for the best interests of their patients and assist patients/clients to understand the information relevant to making decisions to the extent permitted by the patients/clients' capacity.

LEGISLATION

HEALTH CARE CONSENT ACT (HCCA)

The purposes of the *HCCA* are:

(a) to provide rules with respect to consent to treatment that apply consistently in all settings;

(b) to facilitate treatment, admission to or confining in care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

(c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to or confining in a care facility is proposed and persons who are to receive personal assistance services by,

(i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,

(ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to or confining in a care facility or personal assistance services, and

(iii) requiring that wishes with respect to treatment, admission to or confining in a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

(d) to promote communication and understanding between health practitioners and their patients or clients;

(e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, an admission to or a confining in a care facility or a personal assistance service; and

(f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to or confining in a care facility or personal assistance services.

SUBSTITUTE DECISION ACT (SDA)

The *SDA* deals with decision making about personal care (and/or property) on behalf of incapable persons and involves the appointment of substitute decision makers (SDMs). Please see section on SDMs on pages 18 – 19.

TREATMENT

The *HCCA* defines a **treatment** to mean "*anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan*". In this context, treatment does not include,

(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to or confining in a care facility or a personal assistance service, the assessment for the purpose of the Substitute Decisions Act, 1992 of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,

(b) the assessment or examination of a person to determine the general nature of the person's condition,

(c) the taking of a person's health history,

(d) the communication of an assessment or diagnosis,

(e) a person's confining in a care facility,

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment. [*HCCA* 199 s. 2(1)]

PLAN OF TREATMENT

The *HCCA* defines the plan of treatment to mean a plan that

(a) is developed by one or more health practitioners,

(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition. [*HCCA* 1996 s. 2(1)]

In the context of respiratory therapy's scope of practice of, RTs are generally accountable for obtaining consent (or ensuring that consent has been obtained) from patients/clients regarding treatment.

THIRD-PART CONSENT

The *HCCA* also allows for a plan of treatment to be proposed by one health care practitioner on behalf of the health care team involved in the plan. This is referred to as "**third-party consent**" and is acceptable practice provided the consent is informed and obtained prior to initiating the treatment. It is important to remember that if you are the one performing the procedure, you are accountable for ensuring that third-party consent has been obtained. If you have any doubt whether informed consent has been obtained, it is your professional obligation to obtain it, or to not proceed. The definitions of consent and informed consent are discussed in detail in the section about Consent.

SCENARIO:

A patient/client comes to your laboratory for pulmonary function tests and says "My doctor sent me here for some tests."

WHAT DO YOU DO?

You must ensure that your patient's/client's understands the purpose and risks of the tests and verify their consent for the procedure.

CAPACITY

Once the treatment has been ordered, an RT must decide if consent has been obtained or if they need to obtain consent before proceeding. In some situations, RTs may find themselves needing to determine whether or not a patient/client is in fact **capable** to consent to a treatment, and what to do if they suspect the patient is **incapable**.

There are many underlying, and sometimes ethical, principles involved in obtaining consent and determining a person's capacity to consent. One of the first principles to remember is the presumption of capacity. The *HCCA* states:

> *"A person is presumed to be capable with respect to treatment" "A person is presumed to be capable with respect to treatment, admission to or confining in a care facility and personal assistance services."* and
>
> *"A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission, the confining or the personal assistance service, as the case may be."*
> [*HCCA* 2017, c. 25, Sched. 5, s. 56.]

In other words, patients/clients are presumed capable unless, in your professional judgement, you have reasonable grounds to believe that they are incapable of consenting to the treatment or treatment plan you are proposing. The *HCCA* clearly states "*no treatment without consent*". If you believe your patient/client to be incapable, the next step is to find a substitute decision maker.

CAPACITY DEPENDS ON TREATMENT

A person may be incapable with respect to some treatments and capable with respect to others. [*HCCA* 1996, c. 2, Sched. A, s. 15 (1)].

CAPACITY DEPENDS ON TIME

A person may be incapable with respect to a treatment at one time and capable at another. [*HCCA* 1996, c. 2, Sched. A, s. 15 (2)].

WISHES

The *HCCA* states that "*a person may, while capable, express wishes with respect to treatment, to or confining in a care facility or a personal assistance service*" [*HCCA* 2017 c.25, Sched. 5, s. 57]. Expressed wishes must be followed even if the patient/client subsequently becomes incapable.

SCENARIO: A CASE OF COPD EXACERBATION

1. *A COPD patient presenting to the Emergency Department with COPD exacerbation may be capable to consent to an ABG and the administration of oxygen, but may not understand the complexities of intubation.*

2. *The patient with COPD exacerbation may have been able to consent to an ABG when they arrived in the ED but may lose the capacity to consent as their condition worsens, with evidence of impending respiratory failure.*

3. *With the administration of oxygen, the condition of the patient with COPD exacerbation improves. The hypoxemia is corrected and in your professional judgement, their capacity to consent has returned. You are very concerned that this patient may require intubation.*

WHAT SHOULD YOU DO?

In this case, the RT has made a professional judgement that their patient presenting with COPD exacerbation is capable but does not understand the treatment – intubation. In addition, the patient's condition is unstable and their capacity to consent is dependent on their condition at any given time. In order to act in the best interest of the patient, the RT is obligated to seek help from the most responsible physician (and/or other members of the health care team) to discuss their clinical recommendations and findings of capacity. It may be necessary to seek consent from a Substitute Decision Maker (SDM) or to appoint an SDM for the patient. There is also a need to discuss the treatment of intubation with the patient or SDM to ensure that the treatment is understood, and informed consent for treatment (or withholding of treatment) has been received. Finally, it may be an opportune time to discuss the patient's wishes with the patient or SDM surrounding intubation and end of life decision-making.

CONSENT

ELEMENTS OF CONSENT

Once you have determined that your patient is capable to consent to treatment, you must ensure that the four elements of consent are achieved.

The following are the elements required for consent to treatment:

1. Consent must relate to the treatment.
2. Consent must be informed.
3. Consent must be voluntary.
4. Consent must not be obtained through misrepresentation or fraud.

[*HCCA* 1996, s. 11].

INFORMED CONSENT

Informed consent is based on the concept that every person has the right to determine what will be done to their body. This is the principle of autonomy. Informed consent means that the information relating to the treatment has to be received and understood by the patient/client. This may include communication other than speaking. For example, a patient/client with a hearing impairment may need the information provided in writing or by sign language. When a language barrier exists, an interpreter may be needed. It is your responsibility to meet your patient's/client's communication needs to the best of your ability. Using plain language in your explanation of the treatment is one way to facilitate understanding and appreciation of the information relayed.

Consent is informed if:

- the person received information about the treatment or procedure that a reasonable person in the same circumstances would require in order to make a decision about the treatment, including:
  - the nature of the treatment;
  - the expected benefits of the treatment;
  - the material risks of the treatment;
  - the material side effects of the treatment;
  - alternative courses of action;
  - the likely consequences of not having the treatment, and
  - the person received answers to any questions they had about the treatment.

[*HCCA* 1996, s. 11]

IMPLIED AND EXPRESSED CONSENT

Consent may also be implied or expressed.

Implied consent is determined by the actions of the patient/client. Implied consent may be inferred where you are performing a procedure with minimal risk that the patient/client has consented to previously and acts in a manner that implies their consent. For example, if you inform your patient/client that you would like to auscultate their chest and they unbutton their shirt, it may be reasonable to infer that they consent. If you have any doubt at all, you must ensure that the patient/client or their representative consents.

Expressed consent is more official and may be written or oral. For example, having a signed consent form or, having the patient consent to treatment verbally in front of another health care provider are expressed forms of consent. Unless circumstances dictate otherwise, you may presume that consent to a treatment includes consent to a variation in that treatment, provided that the nature, expected outcome, risks and side effects are not significantly different from the original proposed treatment. This presumption is also appropriate where the treatment is being continued in a different location and there remains no significant changes in the expected benefits, risks, or side effects [*HCCA*, section 12].

It is important to remember that consent may be withdrawn at any time and depends on the context of the situation (nature of the treatment, time and place) and the patient's/client's capacity to consent.

If you have reasonable grounds to believe your patient/client is incapable of giving informed consent you will have to obtain informed consent from a Substitute Decision Maker (SDM). (Please refer to the section on Substitute Decision Makers.)

RTs who are unsure whether or not a patient/client is capable to consent should seek assistance, likely from the prescriber of the treatment. Your employer may set out additional policies and procedures to direct your conduct in circumstances where you believe the patient/client is not capable of giving or withholding consent. Where those policies and procedures require you to refer your concerns to a physician or other health care professional then you may defer the finding of incapacity to that health care provider.

For more information on Capacity Assessments visit the Ministry of The Attorney General's The Capacity Assessment Office at: https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacityoffice.php

For more information on Evaluators and Assessors of Capacity in the *Health Care Consent Act* visit: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm

AGE OF CONSENT

The *HCCA* does not identify an age at which an individual may give or withhold consent. This is because the capacity to make independent health care decisions is not dependent on age, but more on the ability to understand the relative risks and benefits of a proposed plan of care. As is outlined in the *Child and Family Services Act*, "consent is an informed process and the patient needs to be able to understand the foreseeable risk of treatment". Therefore, a determination of capacity must be made for minor children and young adolescents in the same manner as it would be for an adult.

SCENARIO: A CASE OF QUESTIONABLE HOME O_2

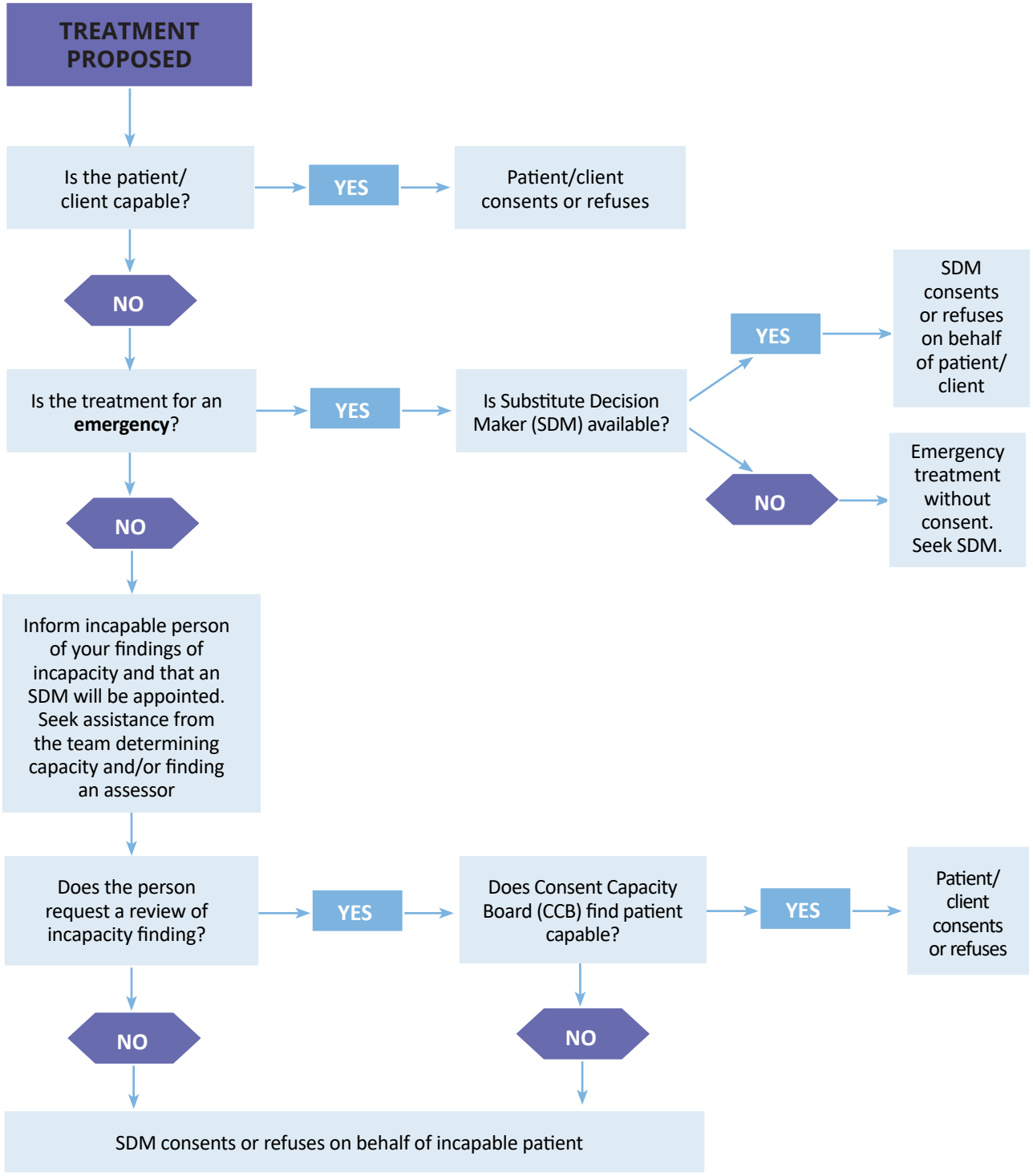
A patient has just been discharged from hospital to home with an order for oxygen. The RT working for the home care company will see the patient in their home to do the set up. The patient is confused and disoriented and does not understand why the RT is in their home or the reason for the oxygen. The RT attempts to explain the equipment, but the patient is not receptive. At this time, it is uncertain if the patient provided informed consent for home oxygen while in hospital. The patient lives alone, has a wood fireplace and a gas stove, and it becomes clear that this is not a safe environment.

The RT shares their concerns with the patient and asks if they have family or friends nearby to help. The patient states they have no family living in the country. The RT contacts the hospital and learns that the home care nurse will not see the patient until tomorrow and you are unsuccessful in reaching the patient's physician. What is the best course of action for the RT at this point?

WHAT SHOULD YOU DO?

In this scenario, the RT has taken all of the right steps to consider the welfare of the patient/client above all else (Standard 14: Safety and Risk Management). They have deemed the client incapable of providing informed consent, informed the patient of their findings, has attempted to contact an SDM and has attempted to engage the health care team for assistance in determining capacity and consent. RTs are not authorized to perform official capacity evaluations or assessments under the *HCCA* or *SDA* respectively. At this time, the best actions for the RT would be to either ensure contact with the ordering/MRP before leaving to arrange an alternate treatment plan or to arrange for the client to return to the hospital from which they had been discharged. It may be a difficult decision and action to take but the RT is ultimately accountable to acting in the best interest of the patient/client. For more information on ethical decision making, please see A Commitment to Ethical Practice.

DECISION TREE
FOR OBTAINING CONSENT TO TREATMENT



INCAPACITY

If you believe a patient/client is incapable with respect to a proposed treatment or treatment plan, then you must tell them that you find them to be incapable. If your patient/client regains capacity with respect to a specific treatment or plan of treatment, after consent was obtained from a substitute decision-maker, then you must tell them that they were found to be incapable to consent at that time.

If at any time your patient/client is sufficiently aware and communicative to understand, you must tell them that they had been found to be incapable. You are not required to tell your patient/client of a finding of incapacity if you believe they would not understand the information due to their age (e.g. newborn) or health condition (e.g. obtunded, or severe dementia).

When you inform a patient/client that there has been a finding of incapacity, you must:

1. Inform the patient/client, that you believe they are not capable of making their own decision with respect to the proposed treatment.
2. Disclose who the substitute decision maker is who will be making treatment decisions on their behalf.
3. Tell the patient/client that they may appeal the finding of incapacity or the choice of substitute decision-maker to the:

   Consent and Capacity Board
   151 Bloor Street West, 10th Floor
   Toronto, Ontario M5S 2T5
   www.ccboard.on.ca
   1-866-777-7391

4. Help the patient/client exercise their rights by (as a minimum) referring the patient/client to the staff person in the hospital or health facility who can provide assistance or by advising the patient/client to contact a lawyer; and
5. Provide this information in a very helpful and sensitive manner that is non-condescending, non-judgmental and non-confrontational.

The situation and circumstance must be properly communicated to the patient/client. Using an interpreter or communication aid may be necessary, depending on the individual patient/client needs.

WHEN CAN YOU
TREAT A PATIENT WITHOUT CONSENT?

1. A treatment may be administered to an **incapable** patient/client without obtaining consent **only** if:
   i. there is an **emergency**; **AND**
   ii. the delay to obtain consent will prolong the suffering that the patient/client is apparently experiencing or will put the patient/client at risk of serious bodily harm [*HCCA*, section 25].
2. A treatment may be administered to an apparently **capable** patient/client without obtaining consent **only** if:
   i. there is an emergency; **AND**
   ii. the communication required to obtain informed consent is not possible due to a language barrier or communication disability; **AND**
   iii. reasonable steps have been taken to enable communication; **AND**
   iv. the delay to further means of enabling the communication will prolong the suffering that the patient/client is apparently experiencing or will put the patient/client at risk of serious bodily harm; **AND**
   v. there is no reason to believe the person does not want the treatment [*HCCA*, section 25].
3. An examination or diagnostic procedure may be performed without obtaining consent provided that:
   i. the examination or diagnostic procedure is necessary to determine whether or not there is an emergency; **AND**
   ii. the health care provider believes the patient/client is incapable or that there is a communication barrier that reasonable efforts have not been able to alleviate [*HCCA*, section 25].
4. In any case where treatment is given without obtaining consent, you must:
   i. document your opinions with respect to capacity and all actions taken (see Documentation PPG) ; **AND**
   ii. continue the treatment only as long as it is reasonably necessary to find a substitute decision maker or to find a practical means to enable communication; **AND**
   iii. ensure that reasonable efforts are made to find a substitute decision-maker or a means of enabling communication [*HCCA*, section 25].

SPECIAL CONSIDERATIONS

In the unfortunate circumstance that this conversation does not occur between the patient and attending physician and you're confident the patient made an informed decision regarding CPR, under your professional obligation, CRTO policy and the CRTO's understanding of the *Health Care Consent Act's* intent, you have an obligation to not initiate this intervention (CPR) and express the patient's wishes to the health care team. Conversely, if you are not confident that the patient made an informed decision, then you would participate in CPR.

SCENARIO: CPR & CONSENT

What should I do if a capable patient/client indicates to me that they would not want any heroic measures to save their life, such as cardiopulmonary resuscitation (CPR), but before the attending physician can write a "Do not resuscitate" order the patient suffers a cardiac/respiratory arrest?

WHAT SHOULD YOU DO?

In order to follow-through on patients'/clients' wishes regarding CPR, it is imperative that the attending physician has a discussion with the patient/client as soon as possible. In the meantime, the CRTO recommends that you take the following actions:

1. At the time that a patient/client makes a statement indicating that they do not want life saving measures, explain to the patient the nature of the treatment intervention (CPR), expected benefits, risks and the consequences of not receiving CPR if it is required. You may also want to very briefly explain what is meant by CPR: e.g. intubation, ventilation, compressions, and defibrillation/cardioversion to establish that the patient/client has made an informed decision about what treatment they are declining.
2. Notify the attending physician immediately and describe what the patient/client has stated.
3. Ask another health care professional, preferably the patient's/client's nurse to witness what the patient has just articulated.
4. Document in the patient's/client's chart a description of the conversation you have had with the patient/client.
5. Follow-up with the attending physician and confirm the resuscitation status of the patient/client.

It is important to recognize and acknowledge that patients/clients may not fully comprehend or appreciate the consequences of not having this life saving intervention. (N.B., understanding and appreciating information are different concepts. Understanding is cognitive. Appreciating information means that patient/client grasps the practical implications of their decision. Informed consent requires both comprehending and appreciating the consequences of the decision.) To that end, it is very important that the patient's attending physician has the opportunity to discuss the likelihood of requiring CPR, the nature of the treatment, expected benefits, risks, alternative treatment options and the consequences of not receiving CPR if required.

SUBSTITUTE DECISION MAKER (SDM)

A Substitute Decision Maker (SDM) is an individual who may give or withhold consent on behalf of an incapacitated patient/ client. The following list of SDMs is in order of priority rank:

1. **Guardian** of the person, if they have authority to give or refuse consent to the treatment
2. **Attorney for personal care**, if they have the authority to give or refuse consent to the treatment
3. Representative appointed by the Consent and Capacity Board, if the representative has the authority to give or refuse consent to the treatment
4. **Spouse** or **partner**
5. Child or parent of the incapable person or children's aid society or other guardian in place of a parent — this does not include a parent who only has right of access
6. A parent with right of access only
7. A brother or sister
8. Any other **relative**
9. The Public Guardian and Trustee [*HCCA*, section 20].

The substitute decision-maker must be:

- capable;
- at least 16 years old, unless they are the parent of the incapable person;
- not prohibited by court order or separation agreement from having access or giving or refusing consent;
- available; and
- willing to assume responsibility [*HCCA*, section 20].

The SDM must also:

- believe that no other person from a higher priority of substitute decision-maker exists or if they exist, that they would not object to them making the decision — if there is an individual who is from priority rank 1, 2, or 3 then this decision-maker must be the one making decisions;
- give or refuse consent in accordance with any known wishes expressed by the incapable person when capable and at least 16 years old; and
- act in the best interests of the incapable person, if no wishes are known or it is impossible to comply with them [*HCCA*, section 21].

Where there are two individuals of the same priority of substitute decision-maker who disagree about whether to give or refuse consent for a treatment, and if their rank is ahead of any other potential substitute decision-maker, then the Public Guardian and Trustee must make the decision.

CONSENT AND CAPACITY BOARD (CCB)

A person who is found to be incapable may apply for a review of the finding to the Consent and Capacity Board [*HCCA*, s. 32]. The only exception to this right is if the person has a guardian with the authority to give or refuse consent to treatment or the person has an attorney for personal care and the power of attorney waives the person's right to apply for a review [*HCCA*, s. 32].

Except in an emergency, you must not begin a treatment or procedure, and you must take reasonable steps to ensure that the treatment or procedure is not started, following a finding of incapacity until:

- 48 hours after you were first informed of an intended application to the Consent and Capacity Board, without an application to the Board being made;
- the application to the Board has been withdrawn;
- the Board has rendered its decision and none of the parties [*HCCA*, s. 32 and 33] have indicated their intention to appeal;
- the time for initiating an appeal from a Board decision has expired without an appeal being launched after a party to the application has informed you that they intend to appeal; or
- the appeal of the Board decision has been finally disposed of. [*HCCA*, s. 18].

WHAT ARE THE PENALTIES FOR FAILURE TO COMPLY WITH THE CONSENT LEGISLATION?

The *HCCA* provides protection from liability for health care practitioners who act on their belief, on reasonable grounds and in good faith, that there was consent for the actions they took [*HCCA*, section 29]. While it may be reasonable to presume that consent has been given unless you have overt signs that it wasn't, the College recommends that you, as a minimum, verify consent for any controlled act you perform.

It is professional misconduct to do "anything to a patient or client for a therapeutic, preventative, palliative, diagnostic, cosmetic or health-related purpose in a situation in which a consent is required by law, without such a consent" [*O. Reg 753/93 - Professional Misconduct*, paragraph 3].

A Member found guilty of professional misconduct **may** be subject to any one or more of the following [*HCCA*, s. 51(2)]:

1. Revocation of the registrant's certificate of registration;
2. Suspension of the registrant's certificate of registration for a specified period of time;
3. Imposition of terms, limitation or conditions on the registrant's certificate of registration for a specified or indefinite period of time;
4. Appearance before the panel for a reprimand;
5. A fine of up to $35,000, payable to the Minister of Finance.

GLOSSARY

Attorney for Personal Care an attorney under a power of attorney for personal care given under the *Substitute Decisions Act*.

Consent and Capacity (the board) A board established by and accountable to the government. Its members are appointed by the government. The Board considers applications for review of findings of incapacity, applications relating to the appointment of a representative, and applications for direction regarding the best interests and wishes of an incapable person.

Capable means mentally capable; a person is capable if they are able to understand the information that is relevant to making a decision about the treatment and are able to appreciate the reasonable foreseeable consequences of a decision or lack of decision — capacity has a corresponding meaning.

College or CRTO College of Respiratory Therapists of Ontario.

Emergency When the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

Guardian of the Person A guardian of the person appointed under the *Substitute Decisions Act*.

HPPC - Health Professions Procedural Code — Schedule 2 of the *Regulated Health Professions Act*.

Incapable Mentally incapable with incapacity having a corresponding meaning.

Partners Individuals who have lived together for at least one year and have a close personal relationship that is of primary importance in both lives.

Plan of Treatment A plan that:

- is developed by one or more health practitioners
- deals with one or more health problems that an individual has, and may deal with one or more problems an individual is likely to have in the future given their current health
- allows for administration of various treatments or courses of treatment.

Relatives Are related by blood, marriage or adoption.

Respiratory Care Equivalent to Respiratory Therapy.

Respiratory Therapist (RT) A Member of the CRTO and includes Registered Respiratory Therapists (RRT), Practical (limited) Respiratory Therapist (PRT) or Graduate Respiratory Therapists (GRT).

GLOSSARY

Spouses Individuals who are married to each other, or who are living in a conjugal relationship and have lived together for at least one year, have a cohabitation agreement or are the parents (together) of a child. Individuals living apart and separate are not spouses.

Treatment Anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment or plan of treatment, but does not include:

- assessment of a person's capacity
- assessment or examination to determine the general nature of an individual's condition
- taking a health history
- communicating an assessment or diagnosis
- admission to a hospital or other facility
- a personal assistance service
- a treatment that, in the circumstances, poses little or no risk of harm

REFERENCES

College of Nurses of Ontario (2017). *Practice Guideline: Consent*. Retrieved from: https://www.cno.org/globalassets/docs/policy/41020_consent.pdf

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College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

This Professional Practice Guideline will be updated as new evidence emerges or as practice evolves. Comments on this guideline are welcome and should be addressed to:

College of Respiratory Therapists of Ontario
180 Dundas Street West, Suite 2103
Toronto, Ontario
M5G 1Z8

Tel	(416) 591 7800	Toll Free	1-800-261-0528
Fax	(416) 591-7890	Email	questions@crto.on.ca

Appendix B: Responsibilities Under Consent Legislation PPG Consultation Survey Results

Answers to Questions
Draft Responsibilities Under Consent Legislation PPG Consultation 2021
As of: 3/1/2022 12:25:28 PM

Page: About You

Question: Are you a...

Respiratory Therapist (including retired)	4	80 %
Student of a Respiratory Therapy Program	1	20 %

Question: I live in...

Ontario	5	100 %

Page: Questions

Question: Is the purpose of the Consent PPG clear?

Yes	No
4	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Do you agree that the Consent PPG is clear and understandable?

Yes	No
4	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Is the Consent PPG free from omissions and/or errors?

Number Who Answered: 4

Yes	No
3	1
75 %	25 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Does this Consent PPG provide you with sufficient understanding of the expectations?

Number Who Answered: 4

Yes	No
3	1
75 %	25 %

Question: If no, please provide further details:

Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?

Number Who Answered: 0

Council Briefing Note

AGENDA ITEM # 3.3 **April 8, 2022**

From:	*Kelly Arndt RRT, Quality Practice Coordinator*
Topic:	*Revised Oxygen Therapy Clinical Best Practice Guideline (CBPG)*
Purpose:	*For Decision*
Strategic Focus:	*Ensuring public and patient safety by providing Respiratory Therapists clear expectations around the safe, ethical administration of oxygen.*
Attachment(s):	Appendix A – Revised Oxygen CBPG Appendix B – Consultation Feedback Summary

PUBLIC INTEREST RATIONALE:

This Clinical Best Practice Guideline (CBPG) provides the public and health care professionals with confidence that the College of Respiratory Therapists of Ontario (CRTO) sets out the expectations for Respiratory Therapists of carrying out their practice safely and ethically when administering oxygen therapy that results in positive health care outcomes for the public of Ontario.

ISSUE:

Previously revised in September 2013, the Oxygen Therapy CBPG has been reviewed and updated to provide a framework for Respiratory Therapists to make informed patient care decisions about oxygen therapy that are safe, ethical, based on current best practices, and evidence based.

BACKGROUND:

Oxygen therapy is an expected competency of all Respiratory Therapists regardless of the practice setting. One of the many aims of this CBPG is to provide tools for Respiratory Therapists who are independently administering oxygen, to mitigate the risks that may be associated with independently administering oxygen therapy in their clinical practice. In addition, this CBPG will provide a framework for clinical best practices regarding oxygen therapy that are current, evidence based and linked to up-to-date resources and learning materials.

ANALYSIS:

Summary of Changes

The format of this document remains in its original version. A jurisdictional and regulatory scan was conducted to confirm that the content of the document is current and accurate. The content has been revised to include gender neutral language, updated links and references, and the addition of a section on Home Oxygen Program (HOP) documents and RTs was included.

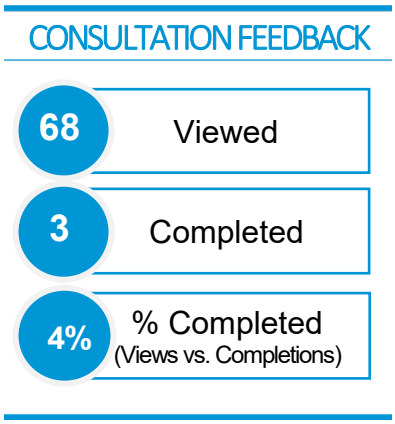
Public Consultation

The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website, tweeted on the CRTO Twitter account and shared with members in the December *e*bulletin. In total, 68 people viewed the consultation survey, and 3 responses were received (all Respiratory Therapists).

There were no comments received. No changes were made to the Oxygen Therapy CBPG as a result of this feedback.

For full consultation results see appendix B.

Date consultation opened: December 13, 2021
Length of time consultation was open: 46-days
Date consultation closed: January 28, 2022



RECOMMENDATION:

It is recommended that the CRTO Council approve the revised Oxygen Therapy CBPG as per the attached motion.

NEXT STEPS:

If the Motion is approved, the CBPG will be published to the website and circulated to CRTO Members.

Council Motion

AGENDA ITEM # 3.3

Motion Title:	*Revised Oxygen Therapy Clinical Best Practice Guideline (CBPG)*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

Council approves the *Revised Oxygen Therapy Clinical Best Practice Guideline (CBPG)* as presented. (A copy is attached as Appendix A to this motion within the materials of this meeting).

Appendix A: Oxygen Therapy CBPG

Revised Oxygen Therapy Clinical Best Practice Guideline (CBPG). This CBPG will also be available to members and the public as a mini website. Please click here if you wish to view. **Note:** this link is still private and will not be available to the public until April 14, 2022, when circulated in the April *e*bulletin.

Date Published: APRIL 2022
Document Number: CBPG-210

OXYGEN THERAPY

CLINICAL BEST PRACTICE GUIDELINE

CLINICAL BEST PRACTICE GUIDELINE

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO (CRTO) PUBLICATIONS CONTAIN PRACTICE PARAMETERS AND STANDARDS SHOULD BE CONSIDERED BY ALL ONTARIO RESPIRATORY THERAPISTS IN THE CARE OF THEIR PATIENTS/CLIENTS AND IN THE PRACTICE OF THE PROFESSION. CRTO PUBLICATIONS ARE DEVELOPED IN CONSULTATION WITH PROFESSIONAL PRACTICE LEADERS AND DESCRIBE CURRENT PROFESSIONAL EXPECTATIONS. IT IS IMPORTANT TO NOTE THAT THESE CRTO PUBLICATIONS MAY BE USED BY THE CRTO OR OTHER BODIES IN DETERMINING WHETHER APPROPRIATE STANDARDS OF PRACTICE AND PROFESSIONAL RESPONSIBILITIES HAVE BEEN MAINTAINED.

RESOURCES AND REFERENCES ARE HYPERLINKED TO THE INTERNET FOR CONVENIENCE AND REFERENCED TO ENCOURAGE EXPLORATION OF INFORMATION RELATED TO INDIVIDUAL AREAS OF PRACTICE AND/OR INTERESTS. BOLDED TERMS ARE DEFINED IN THE GLOSSARY.

It is important to note if an employer's policies are more restrictive than the CRTO's expectations, the RT must abide by the employer's policies. Where an employer's policies are more permissive than the expectations of the CRTO, the RT must adhere to the expectations of the CRTO.

The CRTO will update and revise this document every five years, or earlier, if necessary. The words and phrases in bold lettering can be cross referenced in the Glossary at the end of the document.

ACKNOWLEDGEMENTS

This College of Respiratory Therapists of Ontario (CRTO or College) Clinical Best Practice Guideline (CBPG) was developed by the Professional Practice Committee (PPC) of the CRTO in consultation with Council and other committees of the College, Members at large and staff.

The PPC is a non-statutory committee comprised of Registered Respiratory Therapists (RRT) and public members with a wide range of knowledge and experience from various practice areas across Ontario. This committee was formed by the CRTO in 2010 to focus specifically on the review and development of standards of practice directly related to the practice of Respiratory Therapy in Ontario. By having a standing committee of Respiratory Therapy leaders and experts from core areas of practice, and the ability to draw on additional expertise where necessary, the CRTO aims to ensure consistency in the review and development of publications in a timely fashion. The CRTO would like to acknowledge the work of the PPC, Members at large, and staff in the development of this new CBPG.

PROFESSIONAL PRACTICE COMMITTEE MEMBERS

Paul Williams RRT – Chair (CRTO Council Academic member)
Renee Pageau RRT – Vice Chair (CRTO non-Council member)
Carol-Ann Whalen RRT (CRTO non-Council member)
Allan Cobb (CRTO public member)
Rhonda Contant RRT (CRTO Council member)
Daniel Fryer RRT (CRTO non-Council member)
Alean Jackman RRT-AA (CRTO non-Council member)
Lori Peppler-Beechey RRT (CRTO non-Council member)
Bruno Tassonse RRT (CRTO non-Council member)

CONSULTANT

Raymond Janisse RRT - Certified Hyperbaric Technologist (CHT)

PAST PROFESSIONAL PRACTICE COMMITTEE MEMBERS (2010-2012)

Marisa Ammerata RRT- Vice Chair (CRTO Council member)
Jim Ferrie (CRTO public member)
Ally Ruzycki-Chadwick RRT (CRTO non-Council member)
Sherri Horner RRT-AA (CRTO Member at large)
Kevin Middleton RRT (CRTO Member at large)
Carole LeBlanc RRT – Vice Chair (CRTO non-Council member)
Dave Jones RRT (CRTO Council member)
Tracy Bradley RRT (CRTO Council member)
Mark Pioro (CRTO public member)

2022 REVISION: CRTO STAFF

CONTENTS

INTRODUCTION

PROFESSIONAL PRACTICE ASSUMPTIONS

It is expected that all Respiratory Therapists (RT) in Ontario possess the entry to practice competencies (i.e., knowledge, skills and judgment/abilities) to make sound clinical decisions regarding administration of oxygen (O_2) therapy as part of their education and clinical experience. In addition, the College assumes that all Members:

- Possess a specialized body of knowledge (e.g., about oxygen therapy);
- Are committed to maintaining a high standard of professional practice through self-governance;
- Are committed to lifelong learning and the development of knowledge, skills and abilities throughout their career;
- Are committed to ongoing professional development;
- Are committed to the principle of accountability in their professional practice; and
- Are committed to practicing in an ethical manner.

In addition, Members are expected to remain and to act only within their professional scope of practice, in the best interest of their patients/clients. Please refer to the CRTO Standards of Practice and the Interpretation of Authorized Acts Professional Practice Guideline.

The purposes of this CBPG are many. For example, to:

- Provide a framework for Respiratory Therapists to make informed patient care decisions about oxygen therapy that are safe and ethical;
- Provide a framework for clinical best practices regarding oxygen therapy that are current, evidence based and linked to up-to-date resources and learning materials;
- Support Respiratory Therapists in the maintenance of competency, support ongoing professional development and quality practice; and
- Provide the public and other health care professionals with confidence that Respiratory Therapists are safe and ethical regulated health care professionals with the expertise to administer oxygen therapy that results in positive health care outcomes for the public of Ontario.

GUIDING PRINCIPLES

Therapeutic oxygen should only be administered by competent health care providers who possess the required competencies (knowledge, skill, and judgment/abilities) to make clinical decisions regarding the administration of oxygen. The administration of substances by inhalation is a controlled act under the Regulated Health Professions Act (RHPA) and is authorized under the Respiratory Therapy Act (RTA). The practice of administering oxygen therapy clearly falls within the legislated scope of practice of respiratory therapy which is:

> The *Respiratory Therapy Act* states that the **Scope of Practice** of a Respiratory Therapist is…
>
> *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.*

Oxygen therapy is an expected competency of all Respiratory Therapists regardless of the practice setting. Respiratory Therapists work in a variety of practice settings including but not limited to:

- Acute care (hospitals).
- Complex continuing care.
- Long-term care.
- Independent Facilities (e.g., pulmonary function testing (PFT) labs, sleep labs, ophthalmology clinics).
- Home care.
- Hyperbaric oxygen therapy.
- Anesthesia (e.g., Anesthesia Assistants, dental clinics)
- Independent practice (e.g., consultants).
- Industry.
- Education.

ACCOUNTABILITY

One of the many aims of this guideline is to provide resources and tools for Respiratory Therapists who are independently administering oxygen, to mitigate the risks that may be associated with independently administering oxygen therapy in their clinical practice.

Here are some guiding principles to consider:

- Be accountable, act in the best interest of your patients/clients at all times;
- Ensure safe and ethical care;
- Act within the scope of practice of the profession, the role and scope of where you work and your individual scope of practice;
- Maintain the standards of your profession;
- Ensure that you are competent or become competent to do what you are going to do before you do it;
- Communicate with patients/clients and healthcare providers within the circle of care;
- Educate your patients/clients and healthcare providers within the circle of care; and
- Document… Document… Document!

DID YOU KNOW?

Circle of Care: Sharing Personal Health Information for Health-Care Purposes - IPC

The term "circle of care" is not a defined term in the *Personal Health Information Protection Act, 2004* (*PHIPA*). It is a term commonly used to describe the ability of certain health information custodians to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances defined in *PHIPA*.

To find out more visit the Information and Privacy Commissioner of Ontario at: www.ipc.on.ca

CONFLICT OF INTEREST

A conflict of interest is created when you put yourself in a position where a reasonable person could conclude that you are undertaking an activity or have a relationship that affects or influences your professional judgment.

You must ensure that your professional judgment is not influenced by and does not appear to be influenced by financial or other consideration. You should not be seen, or perceived, to give preferential treatment to any person or organization.

Respiratory Therapists must protect the trust relationship between themselves and their patients/clients. Do not place yourself in a position where a reasonable patient/client, or other person, might conclude that your professional expertise or judgment may be influenced by your personal interests, or that your personal interests may conflict with your duty to act in the best interests of your patient/client. It is not necessary for your judgment to actually be compromised.

For example, a conflict of interest (actual or perceived) may arise if you are the proprietor of a home oxygen company (vendor) and you are the Respiratory Therapist who is assessing and administering oxygen therapy. It could be perceived that you are administering oxygen therapy for personal or financial interests. Please refer to the *Conflict of Interest regulation* and/or the Conflict of Interest Professional Practice Guideline (PPG) on to ensure that, as the RRT independently administering oxygen therapy, you are not in a conflict of interest.

The Ministry of Health and Long Term Care's (MOHLTC) Assistive Devices Program (ADP) has a Conflict of Interest policy that describes possible scenarios where a conflict of interest may exist between registered oxygen **vendors** and **authorizers**. Home oxygen service providers (vendors and authorizers) must be registered with the MOHLTC's ADP **Home Oxygen Program (HOP)** in order to provide home oxygen and respiratory therapy devices to patients/clients in the community. To find out more, visit the MOHLTC's ADP at: http://www.health.gov.on.ca/english/public/program/adp/adp_mn.html

HOP DOCUMENTS AND RTs

The Assistive Devices Program (ADP) has expanded the role of hospital-based and some community-based RRTs by authorizing them to complete the Application for Funding Home Oxygen (application) in place of the prescriber. This expanded role recognizes the specialized training and expertise Respiratory Therapists have regarding oxygen administration, as well as the vital part they play in the implementation of home oxygen

Please follow this link to find important information about this and other recent changes to the ADP-funded home oxygen therapy.

SCOPE OF THIS
CLINICAL BEST PRACTICE GUIDELINE

EVIDENCE-BASED PRACTICE

> "Evidence-based practice is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients/clients. The practice of evidence-based medicine means integrating individual clinical expertise and experience with the best available clinically relevant evidence from systematic research" (*Sackett et al., 1996*).

There is a vast amount of evidence based, clinical information that is readily available on the internet, and this information is constantly changing. This CBPG is not intended to be an all-inclusive oxygen therapy manual or textbook. Rather, this CBPG has been designed for use online and provides links to resources that can be used by RTs (and other users) to pursue their learning and professional development regarding best practices for oxygen therapy.

Specific recommendations for the delivery of oxygen via mechanical ventilation (invasive and non-invasive) and other complex respiratory care devices is beyond the scope of this CBPG.

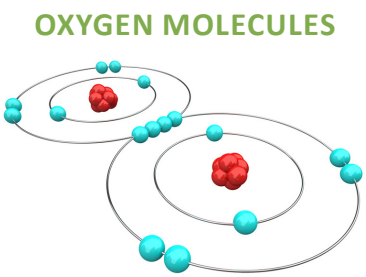
This CBPG will not attempt to discuss the specific use of oxygen or prescribe target oxygen saturations for the treatment of different pathophysiological presentations (e.g., COPD). Alternatively, links to additional evidence based, clinical best practice guidelines will be provided wherever possible (e.g., Canadian Thoracic Society's COPD Guidelines).

This CBPG is informed by the most current evidenced based materials that were available at the time of publication e.g., the guideline British Thoracic Society: Oxygen and the Canadian Thoracic Society documents. The CRTO is committed to maintaining up-to-date and accurate information to the best of its abilities and welcomes input regarding the best practices for oxygen therapy on an ongoing basis.

OXYGEN - A BRIEF REVIEW

Oxygen (O_2) is the eighth element on the periodic table.

At **ambient temperature and pressure (ATP)**, oxygen atoms bind together, sharing electrons to form molecules of oxygen that exist as a colorless, odorless transparent and tasteless gas with the chemical symbol O_2.



Fast Facts about O_2

- Makes up 20.9% of air by volume and 23% air by weight.
- Constitutes 50% of Earth's crust by weight (in air water and combined with other elements).
- Can combine with all other elements except other inert gases to form oxides. Oxygen is therefore characterized as an oxidizer.
- Is a non-flammable gas.
- Accelerates combustion.
- At -182.9 C (-300 F) oxygen is a pale blue liquid.
- Its critical temperature is -118.4 C (above this critical temperature oxygen can only exist as a gas regardless of the pressure).
- An oxygen enriched environment is considered to have 23% oxygen in the air and is a fire hazard.

> "Oxygen sustains life and supports combustion. While there are many benefits to oxygen by inhalation, it is not without hazards and toxic effects. It is therefore important for persons who are responsible for oxygen administration to be familiar with its indications for use, potential hazards and equipment" (Kacmarek, Stoller & Heuer, 2013).

OVERVIEW

TYPES OF OXYGEN DELIVERY SYSTEMS

There are three main types of oxygen delivery systems:

- Compressed gas cylinders;
- Liquid oxygen in cryogenic containers; and
- Oxygen concentrators for medical use.

Considerations for the selection of oxygen source include (but are not limited to) factors such as the size and weight of the device; storage capacity; cost and the ability to fill the device. For a good comparison of portable oxygen source and delivery devices please visit the American Thoracic Society (ATS) website.

DID YOU KNOW?

The manufacturing and distribution of medical oxygen in Canada is primarily regulated by Health Canada who set the standards and guidelines for the manufacturing and distribution of drugs and health products (including medical gases such as oxygen). Their mandate is to ensure medical gases are safe for human and veterinary use.

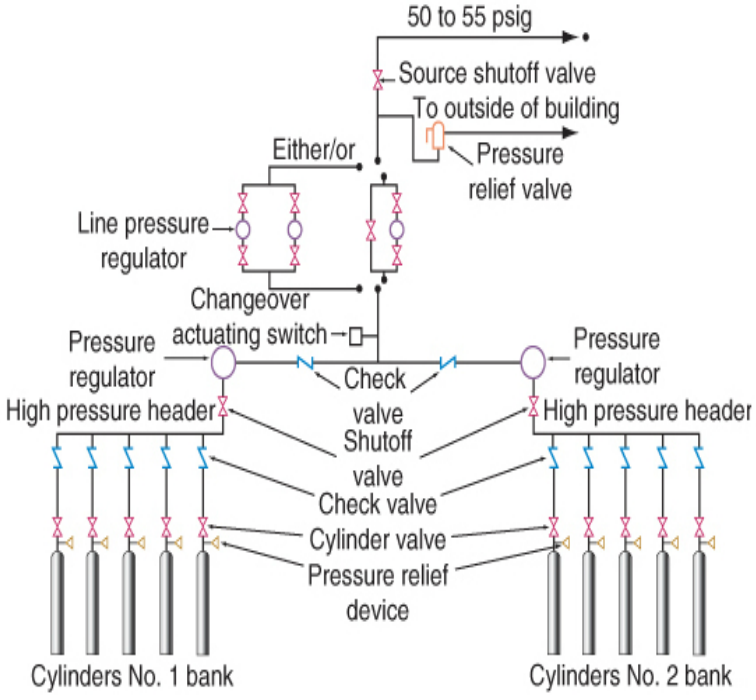
COMPRESSED GAS CYLINDERS

Oxygen is packaged and shipped as a high-pressure gas in seamless steel or aluminum cylinders constructed to Transport Canada and CSA specifications. In cylinders charged with gaseous oxygen, the pressure in the container is related both to temperature and the amount of oxygen in the container. Full high-pressure cylinders normally contain gas at 15 169 kPa (2200 psig) at 21 °C (70°F). Cylinder content can be determined by pressure, i.e., at a given temperature, when the gas pressure is reduced to half the original pressure, the cylinder will be approximately half full. The pressure of a full cylinder of oxygen is normally 2200 psig.

Bulk Oxygen

Cylinders may be used various ways. For example, in a manifold system, large sized cylinders are linked together to supply medical oxygen to medical gas pipelines which then lead directly to the bedside in hospitals.

Manifold System



Modified from Standard for nonflammable medical gas systems, NFPA No. 56F. Copyright 1973, National Fire Protection Association, Boston, MA.

Portable Oxygen Cylinders

Smaller sized cylinders are used as portable individual oxygen systems for short term use.

DID YOU KNOW?

To calculate how long a cylinder will last based on the size of the cylinder and continuous flow rate, the following formula can be used:

Duration of Flow in minutes =

$$\frac{\textbf{(gauge pressure psi - safe residual pressure psi) x cylinder factor}}{\textbf{Flow rate in liters per minute}}$$

Some examples of cylinder factors for different sized cylinders are:

D cylinder 0.16
E cylinder 0.28
M cylinder 1.56
H cylinder 3.14

LIQUID OXYGEN IN CRYOGENIC CONTAINERS

Cryogenic containers store liquefied oxygen and vapour. Various sizes of cryogenic containers exist.

OXYGEN DEWAR

Bulk Liquid Oxygen Systems

Liquid oxygen can be manufactured by **fractional distillation** of air at an oxygen manufacturing plant and then delivered and stored on site to supply the healthcare facility. In this case, large stores of liquid oxygen are referred to as bulk oxygen. The oxygen is stored on site in large **cryogenic vessels** known as dewars. These dewars are regularly refilled by the oxygen gas manufacturer/ supplier.

As the liquid oxygen passes through warming coils and is allowed to evaporate, the gas is delivered to a medical gas pipeline system and then directly to the bedside.

Portable Liquid Oxygen

Various sizes of smaller, base-unit, cryogenic containers (also known as reservoirs) can be used in various settings such as long-term care facilities, homes, and hospital wards to fill smaller portable cryogenic liquid systems that patients can ambulate with. Portable liquid oxygen units offer continuous flow or intermittent flow of oxygen to the patient/client.

The Canadian Standards Association (CSA) offers standards and guidelines on the safety, storage and delivery of liquid oxygen.

TYPES OF OXYGEN DELIVERY SYSTEMS

Oxygen concentrators provide a safe source of oxygen-enriched air. They are devices which employ selective removal of nitrogen from room air to increase the concentration of oxygen in the delivered gas product. A concentrator is an electrical or battery powered, electronically controlled device that does not store oxygen when not in operation.

Bulk Oxygen Supply

Industrial sized oxygen concentrators can supply oxygen to their medical gas pipelines systems which is then delivered directly to the bedside. Concentrators use one of two main methods to separate and concentrate oxygen from the air, molecular serves or semi-permeable membranes.

- Molecular sieves use sodium-aluminum silicate crystals and employ Pressure Swing Adsorption (PSA) or Vacuum Pressure Swing Adsorption (VPSA) technology.
- Semi-permeable membranes are thin plastic membranes that are selectively permeable to O_2 molecules and water vapor.

The CSA offers standards and guidelines on the safety, storage and delivery of bulk oxygen.

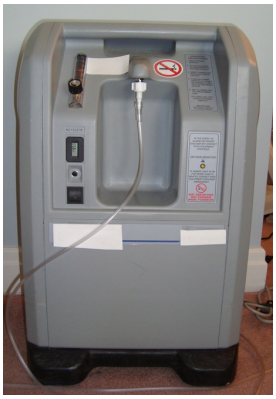
DID YOU KNOW?

Battery operated portable oxygen concentrators can function in continuous flow mode and/or pulse dose/demand mode.

Portable Oxygen Supply

Smaller individual concentrators can provide oxygen at a hospital bedside, in the home or on the go. They also separate oxygen from air using molecular sieves or semipermeable membranes. There are three types:

- stationary concentrators,
- concentrators that have the ability to fill portable aluminum cylinders, and
- portable oxygen concentrators that operate using lithium batteries.



OXYGEN CONCENTRATOR

Oxygen Safety at Home

The CSA has developed standards related to the safe storage, handling and use of portable oxygen systems in residential and healthcare facilities. This is a key resource and includes input from CRTO Members from across Ontario.

The **Canadian Centre for Occupational Health and Safety** also has several resources that are available to the public. You can visit the Canadian Centre for Occupational Health and Safety website and enter the search term 'oxygen' to find out more. Here are some links of interest:

- Compressed Gases Hazards
  http://www.ccohs.ca/oshanswers/chemicals/compressed/compress.html
- Storage and Handling of Compressed Gas Cylinders
  http://www.ccohs.ca/oshanswers/safety_haz/welding/storage.html
- Working with Compressed Gases
  http://www.ccohs.ca/oshanswers/prevention/comp_gas.html
- How Do I Work Safely with Cryogenic Liquids?
  http://www.ccohs.ca/oshanswers/prevention/cryogens.html#_1_7

The safety, labeling, handling and transport of medical oxygen containers is regulated by federal legislation including:

- Transport Canada - Transportation of dangerous goods
  Oxygen is a Class 2.2, Non-flammable, Non-toxic gases.
- Health Canada – Workplace Hazardous Materials Information System (WHMIS).

Oxygen is a Class A: compressed gas.

Manufacturers of therapeutic oxygen in Canada are responsible for providing WHMIS Material Safety Data Sheets (MSDS) for oxygen and may be found on their websites.

OXYGEN THERAPY

HEALTH CANADA AND THE FOOD AND DRUG ACT

According to the *Food and Drug Act*:

> *a "drug" includes any substance or mixture of substances manufactured, sold or represented for use in*
>
> *a) the diagnosis, treatment, mitigation or prevention of a disease, disorder or abnormal physical state, or its symptoms, in human beings or animals,*
>
> *b) restoring, correcting or modifying organic functions in human beings or animals, or*
>
> *c) disinfection in premises in which food is manufactured, prepared or kept;*

DID YOU KNOW?

Health Canada administers the *Food and Drug Act*.

Once a drug has been authorized, Health Canada issues an eight-digit **Drug Identification Numbers (DIN)** which permits the manufacturer to market the drug in Canada.

Health Canada sets the standards and guidelines for the manufacturing of drugs and health products (including medical gases such as oxygen) to ensure they are safe for human and veterinary use.

In Canada, medical oxygen containers and systems require proper labels which include DINs.

AN OVERVIEW OF THE PHASES OF DRUG ACTION adapted from (Rau, J.L., 2002. p. 13)

DRUG ADMINISTRATION

- Consider dosage and route of administration(i.e., by inhalation).

PHARMACOKINETIC PHASE

- Oxygen Transport and Gas Exchange.
  - Absorption.
  - Distribution.
  - Metabolism.
  - Elimination.

PHARMACODYNAMIC PHASE

- Drug and Receptors.
- Cellular Respiration.

EFFECT

- To treat hypoxemia, hypoxia.
- Potential adverse effects.

INDICATIONS FOR OXYGEN THERAPY

- Documented hypoxemia, defined as a decreased PaO_2 in the blood below normal range. PaO_2 of < 60 torr or SaO_2 of < 90% in patients breathing room air, or with PaO_2 and/or SaO_2 below desirable range for specific clinical situation. Clinical acceptable ranges may depend on patient age, condition and/or disease process.
- An acute situation in which hypoxemia is suspected. Substantiation of hypoxemia is required within an appropriate period of time following initiation of therapy.
- Severe trauma.
- Short-term therapy (e.g., carbon monoxide poisoning) or surgical intervention (e.g., post-anesthesia recovery).
- Pneumothorax absorption.

DID YOU KNOW?

The evidence-based approach to the treatment of COPD with oxygen is ever evolving. The American Thoracic Society released a new set of guidelines in 2020:

New COPD Oxygen Therapy Guidelines

"Oxygen is a treatment for hypoxemia, not breathlessness. Oxygen has not been proven to have any consistent effect on the sensation of breathlessness in non-hypoxemic patients." (BTS 2017)

ABSOLUTE CONTRAINDICATIONS & POSSIBLE ADVERSE EFFECTS

Absolute Contraindications

- Patient/Client does not consent to receiving the oxygen.
- The use of some O_2 delivery devices (e.g., nasal cannulas and nasopharyngeal catheters in neonates and pediatric patients that have nasal obstructions).

Potential Adverse Effects

- Oxygen toxicity.
- Oxidative stress.
- Depression of ventilation in a select population with chronic hypercarbia.
- Retinopathy of prematurity.
- Absorption atelectasis.

GOALS OF OXYGEN THERAPY

"Oxygen Therapy is usually defined as the administration of oxygen at concentrations greater than those found in ambient air" (BTS, 2011. p.vi27).

The main goal of oxygen therapy is:

> "To treat or prevent hypoxemia thereby preventing tissue hypoxia which may result in tissue injury or even cell death" (BTS, 2011. p.vi27).

DID YOU KNOW?

Hypoxia can exist even though hypoxemia has been corrected with oxygen therapy?

For example:

- At the cellular level where the cells are unable to access or use the O_2 delivered
- At the tissue level when O_2 may not reach the cells due to a blocked artery

The causes of hypoxia are (BTS, 2011, p.vi14):

- Hypoxemia (e.g., at high altitudes).
- Anemic hypoxemia (e.g., reduced hematocrit or carbon monoxide poisoning).
- Stagnant hypoxemia (e.g., shock, ischemia).
- Histotoxic hypoxia/dysoxia (e.g., cyanide poisoning).

Hypoximia

If the partial pressure of O_2 (PaO_2) is less than the level predicted for the individual's age, hypoxemia is said to be present.

Some of the causes of hypoxemia are:

- Low $P_{inspired}$ O_2 (e.g., at high altitude).
- Hypoventilation, V/Q mismatch (e.g., COPD).
- Anatomical Shunt (e.g., cardiac anomalies).
- Physiological Shunt (e.g., atelectasis).
- Diffusion deficit (e.g., interstitial lung disease).
- Hemoglobin deficiencies.

DID YOU KNOW?

There is Medical Eligibility Criteria for exertional hypoxemia, as well as special considerations for patients diagnosed with pulmonary fibrosis.

DID YOU KNOW?

In Ontario, the MOHLTC sets guidelines defining hypoxemia and the criteria for long-term use of oxygen. The criteria are:

- Each applicant's condition must be stabilized and treatment regimen optimized before long-term oxygen therapy is considered. Optimum treatment includes smoking cessation.
- Applicants must have chronic hypoxemia on room air at rest ($Pa0_2$ of 55mmHg or less, or $Sa0_2$ of 88 % or less).
- Applicants with persistent $Pa0_2$ in the range of 56 to 60 mmHg may be considered candidates for long-term oxygen therapy if any of the following medical conditions are present:
  - cor pulmonale;
  - pulmonary hypertension; or
  - persistent erythrocytosis.

  Also, some applicants with a persistent Pa02 in the range of 56 to 60mmHg may be candidates for long-term oxygen therapy if the following occurs:
  - exercise limited hypoxemia;
  - documented to improve with supplemental oxygen;
  - nocturnal hypoxemia.

Retrieved from: www.health.gov.on.ca/en

The Effects of Hypoxia and Hyperoxia (O'Driscoll, 2008)

HYPOXIA		
	EFFECTS	**RISKS**
Respiratory system	• Increased ventilation • Pulmonary vasoconstriction	• Pulmonary hypertension
Cardiovascular system	• Coronary vasodilation • Decreased systemic vascular resistance (transient) • Increased cardiac output • Tachycardia	• Myocardial ischemia/infarction • Ischemia/infarction of other critically perfused organs • Hypotension • Arrhythmias
Metabolic system	• Increased 2,3-DPG • Increased CO_2 carriage (Haldane effect)	• Lactic acidosis
Neurological system	• Increased cerebral blood flow due to vasodilation	• Confusion • Delirium • Coma
Renal system	• Renin-angiotensin axis activation • Increased erythropoietin production	• Acute tubular necrosis

HYPEROXIA		
	EFFECTS	**RISKS**
Respiratory system	• Decreased ventilation	• Worsened ventilation/perfusion matching • Absorption atelectasis
Cardiovascular system		• Myocardial ischemia (in context of decreased haematocrit) • Reduced cardiac output • Reduced coronary blood flow • Increased blood pressure • Increased reactive oxygen species
Metabolic system	• Decreased 2,3-DPG • Decreased CO_2 carriage (Haldane effect)	• Increased reactive oxygen species
Neurological system	• Decreased cerebral blood flow	
Renal system		• Reduced renal blood flow

2,3-DPG, 2,3-diphosphoglycerate.

Drive to Breathe and Carbon Dioxide Retention

The primary goal of oxygen therapy is to treat hypoxemia. However, a very small number of patients with Chronic Obstructive Pulmonary Disease (COPD) have sensitivity to higher levels of O_2.

Target saturation for patients at risk of hypercapneic respiratory failure is 88-92% (BTS, 2016) unless otherwise prescribed, pending blood gas results.

If you are unsure if a patient has a sensitivity to O_2, the main goal is to treat hypoxemia.

For more information on best practice guidelines for the *treatment of COPD* please visit the Canadian Thoracic Society - COPD Guideline Library website.

Emphasis is always to avoid harmful hypoxemia and hypercapnia by carefully titrating O_2 and monitoring arterial blood gases.

DID YOU KNOW?

Normal range of Carbon Dioxide (CO_2) is generally accepted as 35-45 mmHg.

Normally, increased levels of CO_2 will stimulate ventilation. Patients with certain respiratory diseases such as COPD may have reduced sensitivity to increased levels of CO_2.

Hypoxic drive refers to the patient being dependent on low levels of arterial blood oxygen (PaO_2) to stimulate breathing as seen is some patients with COPD.

If too much O_2 is given to a patient who relies on hypoxic drive to breathe, the blood oxygen levels will rise but the CO_2 level will rise as well, leading to respiratory acidosis and failure.

HOW DOES OXYGEN THERAPY WORK?

In order to better understand how oxygen therapy can correct hypoxemia the following section provides an overview of the physiology of oxygen transport and gas exchange.

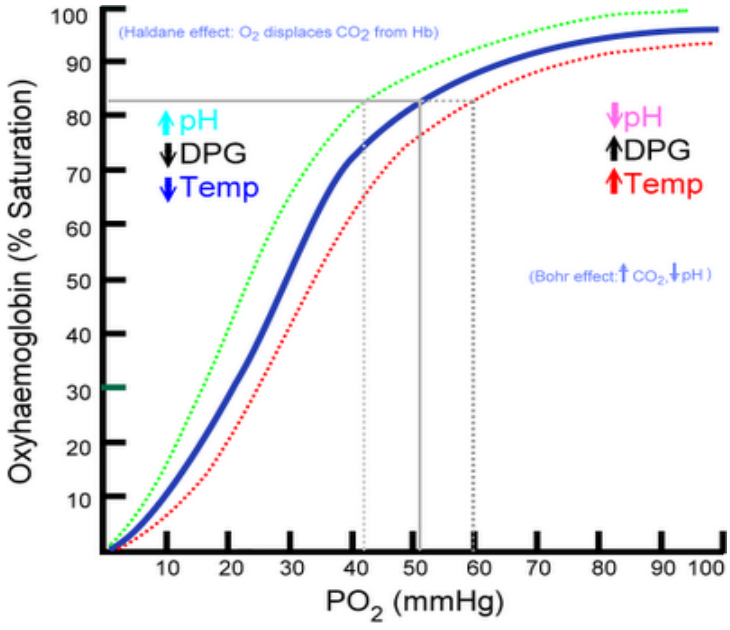
Oxygen Transport

Oxygen carried in the blood is reversibly bound to the hemoglobin. A very tiny amount of free oxygen gas dissolved in the plasma. Dissolved oxygen gas exerts a pressure in the vasculature that can be measured from a blood sample [e.g., an arterial blood gas (ABG)]. This measurement is known as the partial pressure of oxygen in the arterial blood and is represented by the nomenclature: PaO_2.

The majority of oxygen carried in the blood is transported bound to hemoglobin. A very small amount of oxygen gas is transported dissolved in the plasma. This dissolved O_2 can be measured utilizing a small sample of arterial blood. This measurement is referred to as PaO_2 and is an important indicator when assessing for hypoxia.

Oxygen Hemoglobin Dissociation Curve

Oxygen transport can be explained and depicted by the oxygen-hemoglobin dissociation curve.



The oxyhemoglobin dissociation curve is tool for understanding how our blood carries and releases oxygen. In the oxyhemoglobin dissociation curve, oxygen saturation (sO_2) is compared to the partial pressure of oxygen in the blood (pO_2), and this creates a curve that demonstrates how readily hemoglobin acquired and releases oxygen molecules into the fluid that surrounds it (oxygen- hemoglobin affinity).

Some of the factors affecting the loading and unloading of oxygen are:

- blood pH (**Bohr effect**).
- body temperature.
- erythrocyte concentration of certain organic phosphates (e.g., 2,3 diphosphoglycerate).
- variation to the structure of the hemoglobin (Hb) molecules e.g., sickle cells, methemoglobin (metHb) and fetal hemoglobin (Hb F.)
- chemical combinations of Hb with other substances (e.g., carbon monoxide).

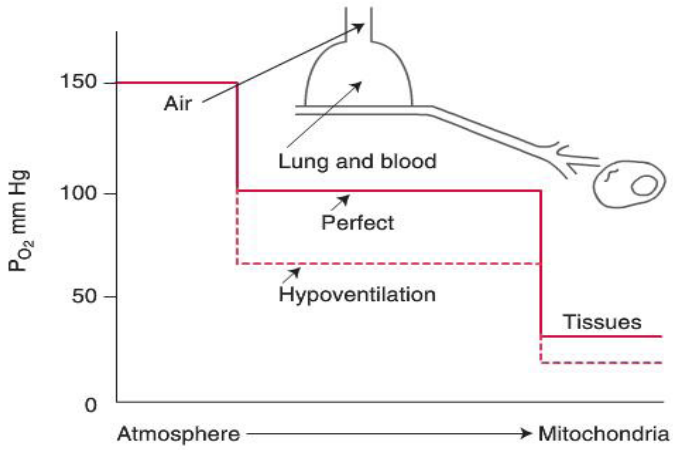
Remember, changes to and of these factors may cause the oxygen dissociation curve to shift right or left; affecting the oxygen-hemoglobin affinity.

Gas Exchange of Oxygen

The movement of oxygen at the level of the microcirculation occurs mainly by passive diffusion. Oxygen is delivered via the respiratory tract to the alveoli and then diffuses across the alveolar-capillary membrane into the blood.

Oxygen Cascade

The diffusion or driving pressure gradients for oxygen between the atmospheric air, alveolus, artery, and tissue capillary.



Alveolar Air Equation

$PAO_2 = [(PB-PH_2O) * FiO_2] - PaCO_2 / RQ$

Normal Diffusion of Oxygen

With regards to diffusion of oxygen in the normal lung at **Body Temperature and Pressure Saturated (BTPS)**:

- the partial pressure of oxygen in the alveolus (P_AO_2) approximates 100mmHg.
- the partial pressure of oxygen in the venous blood returning to the lung (P_VO_2) approximates 40mmHg, there is a pressure gradient for diffusion of oxygen into the blood of about 60 mmHg.
- theoretically, the partial pressure in the capillary blood should rise to equal the partial pressure of oxygen in the alveolus and therefore the partial pressure of oxygen in the arterial blood (PaO_2) should approximate 100mmHg "the PaO_2 of healthy individuals breathing air at sea level is always approximately 5-10 mmHg less than the calculated PaO_2. Two factors account for this difference: (1) right to left shunts in the pulmonary and cardiac circulation and (2) regional differences in the pulmonary ventilation and blood flow" (Kacmarek, Stoller, Heuer, 2013, p. 255). Normal PaO_2 is expected to range from 90-95mmHg however, in clinical practice normoxemia in adults and children is defined as 80-100 mmHg.
- Neonates have a lower actual PaO_2 than adults and children. In neonates normoxemia is 50-80mmHg due to anatomical shunts at birth and the nature of fetal hemoglobin.

At the tissue level, oxygen diffuses from the blood ($P_{capillaries}\ O_2$ = 40 mmHg) across the microvasculature and interstitial space into the cell ($P_{intracellular}\ O_2$ = 5mmHg) where cellular respiration take place.

The movement of gas across the alveolar-capillary membrane is best described by Fick's first law of diffusion.

Fick' Law of Diffusion

$$V = \frac{A \times D}{T} (P1-P2)$$

Where the factors affecting gas exchange are:

V = flow of gas (oxygen)
A = cross sectional area available for diffusion
D = diffusion coefficient
P1 - P2 is the partial pressure gradient
P1 = partial pressure of oxygen in the alveolus (P_AO_2)
P2 = partial pressure of oxygen in the blood (P_aO_2)
T = thickness of the membrane (alveolar-capillary membrane)

Pathophysiological Factors Affecting Gas Exchange

Some of the pathophysiologic factors affecting the gas exchange of oxygen include:

- the flow of oxygen into the lungs, down to the alveoli (hypoventilation and hyperventilation);
- the flow of blood into the lungs to the pulmonary capillaries (vasoconstriction, thrombosis);
- the matching of blood flow and gas flow in the lungs;
- ventilation perfusion mismatching (pneumothorax), decreased cardiac output (MI, shock);
- the carrying content of the blood (SaO_2 and PaO_2) e.g. sickle cell anemia, carbon monoxide poisoning, hypoxemia;
- the pressure gradient for diffusion of O_2 (e.g., hypoxemia);
- the thickness of the alveolar-capillary membrane (e.g., pulmonary fibrosis , pneumonia);
- the thickness of the microvasculature/interstitial space at the tissue (e.g., necrosis).

OXYGEN THERAPY

EQUIPMENT AND ADJUNCTS

The main components of an oxygen delivery system are:

Oxygen Source
- Compressed Gas Cylinders
- Liquid Oxygen in Cryogenic Containers
- Oxygen from Concentrating

→ **Pressure Reducing Valve** → **Patient Outlet** → **Flow Meter** →

Oxygen Delivery Device at the Patient Interface
- Low Flow O_2 Therapy
- High Flow O_2 Therapy
- +/- Humidity Therapy

GUIDING PRINCIPLES

There are many factors to consider when choosing the most appropriate Oxygen Source for patients/clients in their environment (e.g., from hospital to home). For example:

- Continuous flow versus oxygen **conserving devices** (e.g., test patient on specific conserving devices to ensure the therapy meets the patient's requirements).
- Patient physiological needs (e.g., of a neonate with congenital heart disease versus a pregnant female).
- Patients physical abilities (e.g., strength to use equipment).
- Patients cognitive ability (e.g., patient/client ability to understand and use and demonstrate use).
- Environmental Considerations (e.g., site assessment for open flames in the home).
- Geographic considerations (e.g., remote patients

For more information please refer to:
Acute oxygen therapy: a review of prescribing and delivery practices (nih.gov)

DID YOU KNOW?

Not all **oxygen conserving devices** work the same way. For example, some regulators are battery operated, while others are pneumatically powered.

OXYGEN DELIVERY AT THE PATIENT/ CLIENT INTERFACE

Low Flow Oxygen Delivery Devices

Low flow oxygen delivery devices provide a variable FiO_2 depending on the patient's/ client's inspiratory demands. As the inspiratory demands increase, ambient air is entrained and the FiO_2 is diluted.

Examples of low flow devices include:

- Nasal Cannula
- Nasal Catheter
- Transtracheal Catheter
- Simple Mask
- Partial Rebreather Mask
- Non-Rebreather Mask

DID YOU KNOW?

Low Flow Oxygen delivery devices could still deliver a high FiO_2?

Theoretically, a reservoir mask set at 10 -15 L/min, could provide an FiO_2 of 1.0 if it fit properly to a patient's face and met the patient's inspiratory flow demands on every breath.

Nasal Cannula

Today's nasal cannula has evolved to be the most common appliance for oxygen therapy. Permutations of the standard device include:

- models sized for neonatal and pediatric patients,
- incorporation with eye glasses,
- a single prong for sidestream sensing of exhaled carbon dioxide,
- reservoir systems (moustache and pendant) used primarily in long-term ambulatory care,
- a sensor to allow flow only on inspiratory demand (also used primarily in long-term ambulatory care),
- high-flow designs for adult and neonatal/pediatric patients.

High Flow Oxygen Delivery Devices

High flow oxygen delivery devices will provide a fixed FiO_2 (0.24-1.0) regardless of the patient's/client's inspiratory demands.

Some examples of high flow devices include:

- Air Entrainment Mask (Venturi);
- Air entrainment Nebulizer;
- Nasal High Flow Oxygen Therapy;
- Invasive mechanical ventilators;
- Non-Invasive Ventilation machines;
- Resuscitation Bags; and
- Hyperbaric Oxygen Chambers.

DID YOU KNOW?

Mouth breathing does not significantly decrease the FiO_2 delivered by nasal prongs.

DID YOU KNOW?

Nasal High Flow Oxygen Therapy (NHF) can be an alternative to standard high-flow face mask (HFFM) oxygen therapy. It provides delivery of up to 60 L/min of heated and humidified, blended air and oxygen via wide-bore nasal cannula.

OXYGEN THERAPY AND HUMIDITY

Humidity refers to the water vapor content of a gas. In a healthy individual air is delivered to the alveoli at Body Temperature and Pressure Saturated (**BTPS**). Much of the humidification of the air we inspire normally takes place via the nasal passages and upper airway. When a patient receives a supplemental medical gas, it is generally cool and dry and can cause drying of the secretions and mucosa potentially leading to airway obstruction and tissue injury. A goal of humidity therapy is to minimize or eliminate the humidity deficit that may occur when a patient/client breaths a dry medical gas. Humidity therapy is therefore an integral part of oxygen therapy.

Ideally inspired gas should be humidified to 37 C and 44 mg H2O/L (Wattier & Ward, 2011. p. 265). This ensures patient comfort and promotes respiratory health by optimizing mucocilliary function and the clearance of secretions. There are several types of humidifiers that can be used with low or high flow oxygen therapy devices.

Clinical Signs and Symptoms of Inadequate Airway Humidification

- Atelectasis
- Dry, non-productive cough
- Increased airway resistance
- Increased incidence of infection
- Increased work of breathing
- Substernal pain
- Thick dehydrated secretions

Low Flow Oxygen Humidifiers

- Molecular Humidity - bubble type humidifiers, bubble-diffuser type humidifiers used with nasal cannula.
- Humidity is not indicated at flows less than 4 L/min (BTS Guidelines, 2008).
- The use of humidity is not recommended with reservoir type masks as condensates may affect the function of the mask (parts stick together).

High Flow Oxygen Humidifiers

- Molecular Humidity
  - » Passover-type (+/- wick, +/- heater) (e.g., used to humidify trach mask systems, incubators).
- Aerosol Humidity
  - » air entraining jet nebulizers (+/- baffles, +/- heaters)

SPECIAL CONSIDERATIONS

NEONATAL CARE

Providing oxygen therapy to the neonatal population is complex and based on each individual clinical situation. For the immediate newborn period, it is generally accepted that oxygen is provided based on the American Academy of Pediatrics' *Textbook of Neonatal Resuscitation* using the Canadian Adaptations from Canadian Pediatric Society.

Resources:

Canadian Pediatric Society (2020). 7th Edition NRP Guidelines. Retrieved from: https://cps.ca/en/nrp-prn/faqs#Oxygen%20Administration

Low Flow Oxygen typically refers to oxygen delivered via nasal prongs/cannula at a flow rate 500 ml/min or less. Humidification of the oxygen is dependent on the flow rate and hospital policies. It is important to remember that it is possible to deliver high concentrations of oxygen with low flows depending on anatomic dead-space and the minute ventilation of the patient.

HYPERBARIC OXYGEN THERAPY (HBOT)

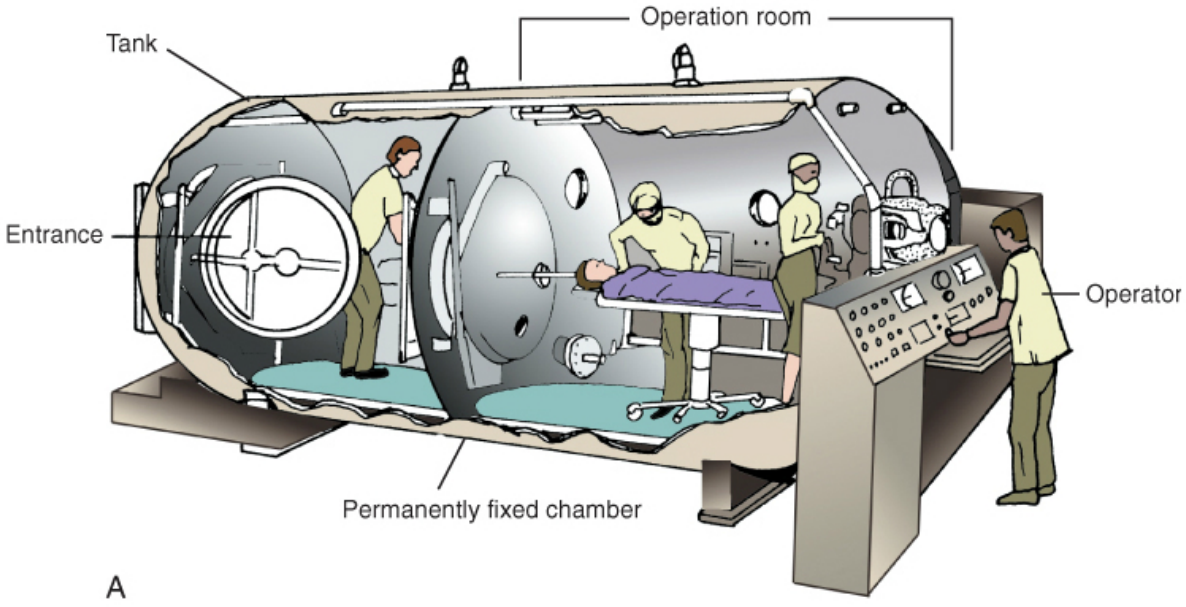
DID YOU KNOW?

The Undersea and Hyperbaric Medical Society (UHMS) is an international, non-profit organization and is generally considered a primary source of scientific information for diving and hyperbaric medicine physiology worldwide.

Health Canada refers to UHMS guidelines and the CSA sets the standards for hyperbaric therapy in Canada.

The Basic Principles of Operation of Hyperbaric Chambers

The increased pressure inside the chamber, combined with the delivery of 100% oxygen (FiO_2 = 1.0), drives the diffusion of oxygen into the blood plasma at up to 10 times normal concentration. Patients are monitored at all times during HBOT, often by RTs.



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PHYSIOLOGIC EFFECTS OF HYPERBARIC OXYGEN THERAPY

While some of the mechanisms of action of HBOT, as they apply to healing and reversal of symptoms, are yet to be discovered, it is known that HBOT:

- greatly increases oxygen concentration in all body tissues, even with reduced or blocked blood flow;
- stimulates the growth of new blood vessels to locations with reduced circulation, improving blood flow to areas with arterial blockage;
- causes a rebound arterial dilation after HBOT, resulting in an increased blood vessel diameter greater than when therapy began, improving blood flow to compromised organs;
- stimulates an adaptive increase in superoxide dismutase (SOD), one of the body's principal, internally produced antioxidants and free radical scavengers; and,
- aids the treatment of infection by enhancing white blood cell action and potentiating germ-killing antibiotics.

Indications

As of 2019, the following indications are approved uses of hyperbaric oxygen therapy as defined by the Undersea & Hyperbaric Medical Society (UHMS):

1. Air or Gas Embolism
2. Carbon Monoxide Poisoning
   Carbon Monoxide Poisoning Complicated By Cyanide Poisoning
3. Clostridial Myositis and Myonecrosis (Gas Gangrene)
4. Crush Injury, Compartment Syndrome and Other Acute Traumatic Ischemias
5. Decompression Sickness
6. Arterial Insufficiencies:
   Central Retinal Artery Occlusion
   Selected problem wounds – diabetic ulcers
7. Severe Anemia
8. Intracranial Abscess
9. Necrotizing Infections
10. Osteomyelitis (Refractory)
11. Delayed Radiation Injury (Soft Tissue and Bony Necrosis)
12. Compromised Grafts and Flaps
13. Acute Thermal Burn Injury
14. Idiopathic Sudden Sensorineural Hearing Loss*
    (*approved on October 8, 2011 by the UHMS Board of Directors)

POTENTIAL COMPLICATIONS OF HYPERBARIC OXYGEN THERAPY

- Barotrauma:
  - ear or sinus trauma
  - tympanic membrane rupture
  - alveolar over distension and pneumothorax
  - gas embolism
- Oxygen Toxicity
  - central nervous system toxic reaction (**Early signs of impending CNS toxicity include twitching, sweating, pallor and restlessness. These signs usually are followed by seizures or convulsions**)
  - pulmonary toxic reaction
- Other
  - Fire
  - Sudden decompression
  - Reversible visual changes
  - Claustrophobia
  - Decreased Cardiac Output (Cairo & Pilbeam,2004)

The Safety of Hyperbaric Chambers (Health Canada)

Hyperbaric chambers are class 3 medical devices which must be licensed by Health Canada before they can be imported and sold in Canada. The Medical Devices Regulations require that the medical devices imported and sold in Canada are safe, effective, and of quality manufacture. This is achieved by a combination of a pre-market review prior to licensing, and post-market surveillance of adverse events.

Health Canada has reviewed the scientific evidence related to hyperbaric chambers. The evidence shows that chambers are effective in treating at this time the 14 conditions recognized by the Undersea and Hyperbaric Medical Society. Therefore, Health Canada has issued medical device licences for hyperbaric chambers to treat only these 14 conditions. No device licences have been issued for the use of hyperbaric chambers to treat other conditions.

Undersea and Hyperbaric Medical Society
http://membership.uhms.org/?page=Indications

Undersea and Hyperbaric Medical Society Canadian Chapter
https://cuhma.ca/

University of Toronto HyperbaricMedicine.ca
(educational resource for healthcare professionals)
https://www.uhn.ca/Surgery/Treatments_Procedures/Hyperbaric_Medicine_Unit

ALTITUDE EFFECTS ON THE AVAILABILITY OF OXYGEN

As altitude increases, barometric pressure decreases. Barometric pressure is the pressure that is exerted by the gases at a given point in the atmosphere and is the sum of the partial pressures of the component gases. The composition of the atmosphere does not change with altitude, however, the barometric pressure does. As altitude increases, there is a decrease in the partial pressure exerted by each component gas. Thus, as altitude increases, the partial pressure of oxygen in the alveoli decreases. A reduced partial pressure of oxygen results in a relative hypoxia.

DID YOU KNOW?

In the cabin of a typical commercial aircraft, the pressure exerted is equivalent to the barometric pressure at 5000-8000 feet above sea level. As a result, patients who require oxygen supplementation at the ground level may require increased supplementation at an increased altitude.

The following document is helpful for those planning travel by commercial airline:

Transport Canada – "Passengers with Medical Oxygen"
https://tc.canada.ca/en/aviation/reference-centre/advisory-circulars/advisory-circular-ac-no-700-002#s4-1

It is also helpful to consult the website of the specific airline that the patient intends to travel with for assistance in planning/arranging air travel when oxygen is required.

Hyperbaric Oxygen & the 5th Authorized Act

For some time now, RTs have administered therapeutic oxygen in a hyperbaric practice setting under the 4th authorized act (*"administering a substance by injection of inhalation"*). As previously mentioned, the *Public Hospitals Act* still requires RTs to obtain an order from a valid authorizer to administer oxygen in this environment. As such, there is no change to the existing practices in hyperbaric settings within hospitals in Ontario.

The 5th authorized act, in combination with the *Prescribed Substances* regulation, now permits RTs to independently administer therapeutic oxygen. This means that in a hyperbaric setting outside of a hospital, RTs can administer oxygen without the additional requirement of an order for the oxygen from a physician or other authorizer. Administration of Hyperbaric Oxygen Therapy (HBOT), however, must occur in accordance with a **diagnosis, pre-treatment screening and prescribed treatment profile** (e.g., dive depth/pressure, time, etc.) that have been established by the most responsible physician (MRP). Therefore, RTs cannot independently initiate HBOT, but can implement this treatment in collaboration with the MRP.

HBOT is considered to be within the scope of practice of respiratory therapy; however, it requires competencies that are beyond those that an RT would possess at an entry-to-practice (i.e., graduate) level. In both the hospital and community setting, obtaining credentials as a Certified Hyperbaric Technologist (CHT) from the Undersea and Hyperbaric Medical Society (UHMS) is considered the industry standard, and is the benchmark that any RT administering hyperbaric oxygen would be expected to perform to.

As noted on page 34, the CRTO has endorsed the list of 14 indications for hyperbaric oxygen therapy that are established by the UHMS. Health Canada supports the application of HBOT that is based on the UHMS guidelines and warns against "off label" uses that have not been scientifically proven to be effective. The CRTO does not endorse "off label" use of hyperbaric therapy and the engagement of an RT in such activity may be considered professional misconduct.

ASSESSMENT OF OXYGEN THERAPY

OXIMETRY

Oximetry is the measurement of blood hemoglobin (Hb) saturations using spectrophotometry. Several types of Oximetry are used in clinical practice. The methods most commonly encountered in RT clinical practice include:

- Hemoximetry (also called cooximetry) – performed in arterial blood gas analysis.
- Pulse Oximetry - portable, noninvasive monitoring technique

Pulse Oximetry

Pulse Oximetry provides estimates of arterial blood oxyhemoglobin saturation levels, but as not actual SaO_2 measures. Therefore, pulse oximetry readings are recorded as SpO_2. Supplemental oxygen should be "prescribed" to a target blood hemoglobin saturation according to the population served and clinical presentation (Kacmarek et al, 2013.)

Pulse oximetry can be performed at rest, exercise, and during activity. The $Sp0_2$ measured with the oximeter is widely used in clinical practice. Some refer to the oxygen saturation as the fifth vital sign. It is important to fully understand the appropriate applications and limitations of this technology.

Guidelines for pulse oximetry are available from the **American Association of Respiratory Care (ARRC)** at: https://www.aarc.org/wp-content/uploads/2014/08/08.92.897.pdf

KEY POINTS TO REMEMBER:

- Follow manufacturers protocol;
- Always use compatible sensors;
- Ensure correct type, size and fit of sensor;
- Confirm adequacy and accuracy of reading (validate with ABG Sa02 when applicable);
- Adjust alarm according to the clinical situation;
- Apply standard precautions infection control;
- Inspect and change sensor site as needed;
- Never act on $Sp0_2$ alone, reading should reflect the patient's clinical condition; and
- Avoid using pulse oximetry to monitor hyperoxia in neonates.

This CBPG was not meant to be the last resource you will need to access to answer your clinical and professional practice questions. Alternatively, we have provided you with links to other important resources that you may need to access in order to obtain required information. Websites will change and we encourage you to let us know if you are unable to access any of the websites that we have connected you to. This is a "living document" and will have to adapt as the evidence and clinical best practice guidelines change.

We encourage all CRTO Members to be active in the ongoing development of this CBPG Oxygen Therapy and to continue to advocate for safe and ethical practices in your practice environment.

GLOSSARY

(ATP) Ambient **T**emperature and **P**ressure = **(STP)** standard temperature and pressure = 0C and 1 atmosphere

BTPS = **B**ody **T**emperature and ambient **P**ressure **S**aturated = 37 °C, 1 atmosphere, and 44 mg H2O/L

Conserving Devices How long liquid and cylinder systems last before refilling depends on the amount of oxygen a person uses. Conserving devices extend the length of time. Oxygen systems deliver oxygen continuously during inspiration and exhalation. Conserving devices can be programmed to deliver oxygen during inspiration only, therefore reducing the amount wasted during exhalation.

Cryogenic Vessel A static or mobile vacuum insulated container designed to contain liquefied gas at extremely low temperatures. Mobile vessels could also be known as "**Dewars**". Retrieved from: www.canada.ca/en/health-canada/services/drugs-health-products/compliance-enforcement/good-manufacturing-practices/guidance-documents/gmp-guidelines-0031/document.html

Drug Identification Number (DIN) a computer-generated eight-digit number assigned by Health Canada to a drug product prior to being marketed in Canada. It uniquely identifies all drug products sold in a dosage form in Canada and is located on the label of prescription and over-the-counter drug products that have been evaluated and authorized for sale in Canada. A DIN uniquely identifies the following product characteristics: manufacturer; product name; active ingredient(s); strength(s of active ingredient(s); pharmaceutical form; route of administration. Retrieved from: www.hc-sc.gc.ca/dhp-mps/prodpharma/activit/fs-fi/dinfs_fd-eng.php

Fractional Distillation the process of separating the portions of a mixture by heating it and condensing the components according to their different boiling points. Retreived from: medical-dictionary.thefreedictionary.com/fractional+distillation

Medical Gas (either a single gas or a mixture of gases) is a gas that requires no further processing in order to be administered, but is not in its final package (e.g., liquefied oxygen) and is known as a bulk gas. Retrieved from: ccinfoweb2.ccohs.ca/legislation/documents/stds/csa/cmgpi12e.htm

Manifold (rampe) Equipment or apparatus designed to enable one or more medical gas containers to be filled at a time.

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College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

This Professional Practice Guideline will be updated as new evidence emerges or as practice evolves. Comments on this guideline are welcome and should be addressed to:

College of Respiratory Therapists of Ontario
180 Dundas Street West, Suite 2103
Toronto, Ontario
M5G 1Z8

Tel	(416) 591 7800	Toll Free	1-800-261-0528
Fax	(416) 591-7890	Email	questions@crto.on.ca

Appendix B: OXYGEN THERAPY CPBG Consultation Survey Results

Answers to Questions
Draft Oxygen Therapy CBPG Consultation 2021
As of: 3/1/2022 2:23:45 PM

Page: About You

Question: Are you a...

Respiratory Therapist (including retired)	3	100 %

Question: I live in...

Ontario	3	100 %

Page: Questions

Question: Is the purpose of the Oxygen Therapy CBPG clear?

Yes	No
3	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Do you agree that the Oxygen Therapy CBPG is clear and understandable?

Yes	No
2	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Is the Oxygen Therapy CBPG free from omissions and/or errors?

Number Who Answered: 3

Yes	No
3	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Does this Oxygen Therapy CBPG provide you with sufficient understanding of the expectations?

Number Who Answered: 3

Yes	No
3	0
100 %	100 %

Question: If no, please provide further details:

Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?

Number Who Answered: 0

Council Briefing Note

AGENDA ITEM # 4.1 **April 8, 2022**

From:	*Inquiries, Complaints and Reports Committee*
Topic:	*Revised Disclosure of Witness Statements Policy*
Purpose:	*For Decision*
Strategic Focus:	*In keeping with the CRTO's mandate, fulfilling the CPMF reporting obligations, and meeting its 2021 – 2025 Strategic Direction, this policy has been revised and refreshed due to the new CRTO Policy Framework.*
Attachment(s):	Appendix A: *Revised Disclosure of Witness Statements Policy* Appendix B: *Consultation survey results*

PUBLIC INTEREST RATIONALE:

It is a key statutory responsibility of the College of Respiratory Therapists of Ontario (CRTO) to investigate concerns about members. The policy offers the CRTO ability to protect witnesses in situations that may involve workplace bullying/harassment, who may fear reprisal from the member.

ISSUE:

The Disclosure of Witness Statements Policy was last reviewed by Council on December 5, 2018. It has been updated to reflect the CRTO's new policy template. This document has gone through a rigorous policy review process, including external legal review, to ensure that all legislative and regulatory requirements have been met.

BACKGROUND:

This policy sets direction for CRTO staff and/or the Inquiries, Complaints and Reports Committee (ICRC) that is not stated in the *Regulated Health Professions Act, 1991 (RHPA),* and the *Health Professions Procedural Code (*the *"Code")*, being Schedule 2 of the *RHPA*.

During a Registrar's inquiry or at the ICRC stage, it is the policy of the CRTO to provide a member who is facing allegations of professional misconduct with witness names and statements. However, there are situations during which witness names and statements may be

excluded/redacted if there are reasons to believe that disclosure may result in an unnecessary risk to an individual or the integrity of the inquiry or investigative process.

This policy supports the process for determining when this is appropriate, while maintaining the member's right to procedural fairness.

ANALYSIS:

Summary of Changes
This policy has had significant changes which include:

- The policy's terminology, which has been revised to capture specific types of conduct related to a member's conduct or actions. Specifically, item 1.0 of the policy stated, "unprofessional conduct" and the sentence has been revised to state, "workplace bullying or harassment." Workplace bullying or harassment provides a more accurate description of the type of conduct associated with the potential for perceived threat of reprisal that could result in a person's hesitations to participate in an inquiry or investigation;

- Item 1.0 of the policy stated, "Regulated Health care professionals" and the sentence has been changed to state, "members of the CRTO", this is because this policy is specific to CRTO members, as the CRTO does not have jurisdiction over other healthcare professionals;

- The policy now specifically differentiates between CRTO staff and/or the ICRC, regarding who is assessing the information and disclosing information to the parties involved in the matter. Specifically, item 5.0 of the policy stated, "CRTO staff and the ICRC will" and the sentence has been revised to state, "CRTO staff and/or the ICRC will". This change makes it clear that in situations where the matter is before the Registrar, such as an inquiry, the determination of safety risk is up to the Registrar, and in situations where the matter is before the ICRC, the determination of safety risk is up to the ICRC (not staff); and

- Lastly, item 5.0 of the policy now includes an option of cautioning the member regarding the implications of retaliating against witnesses. This option has been added to account for instances where redaction of materials is not feasible, as it would limit the Registrar or ICRC's ability to investigate the concern.

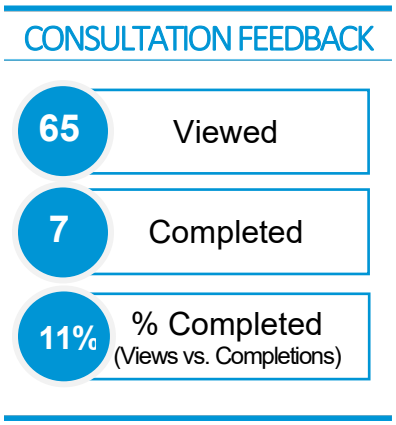
The changes made to this policy are consistent with current policies of the CRTO as this policy strengthens the CRTOs commitment to transparency and regulating the profession of Respiratory Therapy in the public interest.

Public Consultation

The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website and tweeted on the CRTO Twitter account. In total, 65 people viewed the consultation survey, and 7 responses were received (3 Respiratory Therapists, and 1 Health Care Professional other than an RT).

All respondents found the policy clear, understandable, and free from omissions and errors. No comments were received.

For full consultation results see appendix B.



Date consultation opened: November 15, 2021
Length of time consultation was open: 30-days
Date consultation closed: December 15, 2021

RECOMMENDATION:

It is recommended that the CRTO Council approve the Disclosure of Witness Statements Policy as per the attached Motion.

NEXT STEPS:

If the motion if approved the policy will be posted on the CRTO website and communicated to members in the next *e*bulletin.

Council Motion

AGENDA ITEM # 4.1

Motion Title:	*Revised Disclosure of Witness Statements Policy*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

Council approves the revised *Disclosure of Witness Statements Policy*. (A copy of the policy is attached as Appendix A within the materials of this meeting).

Appendix A: Revised Disclosure of Witness Statements Policy

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Disclosure of Witness Statements

Type: Policy

Origin Date: February 26, 2014

Section: CD

Approved By Council on: December 5, 2018

Document Number: CD - 110

Next Revision Date: 5 Years After Approval

1.0 BACKGROUND

Concerns reported to the College of Respiratory Therapists of Ontario (CRTO) about members sometimes relate to workplace bullying or harassment. As a result, witnesses, who are often colleagues of the member who is the subject of the report or complaint, are hesitant to participate in an inquiry or investigation process due to fear of reprisal from the member.

Members of the CRTO have an obligation to cooperate with the CRTO when an inquiry or investigation into their conduct or actions occur. The CRTO recognizes that where concerns related to workplace bullying or harassment are alleged, the potential for perceived threat of reprisal may be greater.

One of the key statutory responsibilities of the CRTO is to investigate concerns about members. The Registrar and/or the Inquiries, Complaints and Reports Committee (ICRC) investigates concerns related to allegations of professional misconduct, incompetence or incapacity. Investigations often include interviewing witnesses regarding the incidents or situations that gave rise to the concerns.

2.0 POLICY STATEMENT

During a Registrar's inquiry or at the ICRC stage, it is the policy of the CRTO to provide a member who is facing allegations of professional misconduct with witness names and statements.

Witness names and statements may be excluded/redacted if there are reasons to believe that disclosure may result in an unnecessary risk to an individual or the integrity of the inquiry or investigative process.

3.0 PURPOSE

The purpose of this policy is to assist the Registrar or the ICRC in determining if identifying information or other information should be withheld or disclosed during an inquiry or

investigation process, while maintaining procedural fairness. In addition, it is designed to provide witnesses with some comfort regarding the protection of their identities and information, if need be, while maintaining the member's right to procedural fairness.

4.0 SCOPE OF POLICY

The scope of this policy applies to all inquiries or investigations by the CRTO and ICRC for concerns related to a member's competency, capacity or conduct.

5.0 RESPONSIBILITIES

When safety risks are identified, CRTO staff and/or the ICRC will consider the member's right to procedural fairness along with the following factors:

(a) Whether the nature of the information may be detrimental to the member (e.g., psychological harm);
(b) Whether the privacy interests of the witness (or an individual to whom the witness refers) would be significantly affected;
(c) Whether other significant concerns have been raised by the witness(es), employer or other party regarding the impact of disclosure.

Options available to address safety risks at the ICRC stage include:

1. excluding the names of witnesses from the Investigation Report;
2. redacting portions of the witness statement;
3. providing the member with a summary of the witness statement;
4. cautioning the member that retaliating against a witness can result in additional allegations of professional misconduct against the member.

6.0 AUTHORITY & MONITORING

Under the *Regulated Health Professions Act, 1991 (RHPA),* the *Health Professions Procedural Code* being Schedule 2 (the *Code*), CRTO By-Laws, and the Regulations under the Respiratory Therapy Act, 1991, all members of the CRTO have an obligation to cooperate with the CRTO.

7.0 RELATED DOCUMENTS

Section 76 (3.1) of the Code

8.0 CONTACT INFORMATION

College of Respiratory Therapists of Ontario
180 Dundas Street West,
Suite 2103
Toronto, ON M5G 1Z8

Telephone: 416-591-7800
Toll-Free (in Ontario): 1-800-261-0528
Fax: 416-591-7890
General Email: questions@crto.on.ca

Answers to Questions
CD-110 Witness Statements Policy Consultation 2021
As of: 2/9/2022 8:53:45 AM

Page: About You

Question: Are you a...

Number Who Answered: 14

Respiratory Therapist (including retired)	14	100 %

Question: I live in...

Number Who Answered: 14

Ontario	14	100 %

Page: Questions

Question: 1. Is the purpose of the Disclosure of Witness Statements policy clear?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 2. Do you agree that the Disclosure of Witness Statements policy is clear and understandable?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 3. Is the Disclosure of Witness Statements policy free from omissions and/or errors?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 4. Does this Disclosure of Witness Statements policy provide you with sufficient understanding of the expectations?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?

Number Who Answered: 0

Council Briefing Note

AGENDA ITEM # 4.2 **April 8, 2022**

From:	*Inquiries, Complaints and Reports Committee*
Topic:	*Revised Health Professions Appeal and Review Board Appeals for ICRC Policy*
Purpose:	*For Decision*
Strategic Focus:	*In keeping with the CRTO's mandate, fulfilling the CPMF reporting obligations, and meeting its 2021 – 2025 Strategic Direction, this policy has been revised and refreshed due to the new CRTO Policy Framework.*
Attachment(s):	Appendix A: *Revised Health Professions Appeal and Review Board Appeals Policy* Appendix B: *Consultation survey results*

PUBLIC INTEREST RATIONALE:

This policy permits timelines of a decision rendered by the Inquiries, Complaints and Reports Committee (ICRC) to take effect only until **thirty-five (35) days** from the date the parties subject to the Decision are notified. The revised version of this policy sets out that the member is permitted to enter into an Acknowledgement and Undertaking (the Agreement) in order to demonstrate compliance and governability.

ISSUE:

The Health Professions Appeal and Review Board Appeals for ICRC Policy was last reviewed by Council on March 4, 2016. It has been updated to reflect the CRTO's new policy template. This document has gone through a rigorous policy review process, including external legal review, to ensure that all legislative and regulatory requirements have been met.

BACKGROUND:

This policy sets direction that is not stated in the *Health Professions Procedural Code* (the *"Code"*) in which a member may enter into an Acknowledgement and Undertaking when offered by the ICRC before the **thirty-five (35) day** timeline begins.

There may be instances where a complainant or member involved in a complaints matter that appeared before the ICRC appeals the decision rendered by the ICRC to the Health Professions Appeal and Review Board (HPARB). This policy states the timelines to be taken into effect, should an appeal be made. Given that not all decisions are the same, this policy takes into consideration circumstances where a member is ordered to enter into an Agreement, and that it is permissible the member engages in entering the Agreement prior to or during the thirty-five (35) day timeline, demonstrating a member's compliance and governability.

ANALYSIS:

Summary of Changes
Although there have been no changes in the policy's intent, based on legal advice, changes that have been made to this policy include:

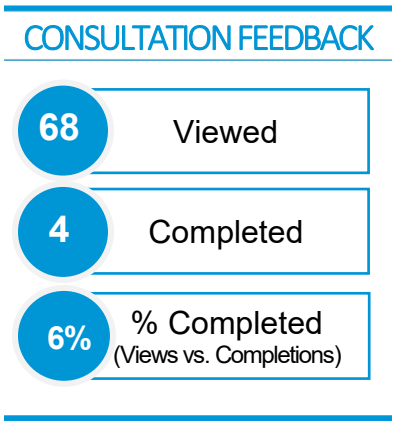
- The title of the policy was changed from *HPARB Appeals Policy* to *Health Professions Appeal and Review Board Appeals for ICRC Policy*;
- Item 1.0 of the policy includes that "this policy does not apply to Acknowledgement and Undertakings between a member and the CRTO, the timelines of which will run in accordance with the terms of such undertakings." This section has been included to provide clarity and confirm that the obligation to fulfil an undertaking runs regardless of an appeal made to HPARB; and
- The policy has been revised for its readability and to incorporate gender-neutral language.

The changes made to this policy are consistent with current policies of the CRTO as this policy strengthens the CRTO's commitment to transparency and regulating the profession of Respiratory Therapy in the interest of the public.

Public Consultation
The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website and tweeted on the CRTO Twitter account. In total, 68 people viewed the consultation survey, and 4 responses were received (all Respiratory Therapists).

All respondents found the policy clear, understandable, and free from omissions and errors. No comments were received.

For full consultation results see appendix B.



Date consultation opened: November 15, 2021
Length of time consultation was open: 30-days
Date consultation closed: December 15, 2021

RECOMMENDATION:
It is recommended that the CRTO Council approve the Health Professions Appeal and Review Board Policy as per the attached motion.

NEXT STEPS:
If the motion is approved, the policy will be posted on the CRTO website and communicated to members in the next *e*bulletin.

Council Motion

AGENDA ITEM # 4.2

Motion Title:	*Revised Health Professions Appeal and Review Board Appeals for ICRC Policy*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

Council approves the revised *Health Professions Appeals and Review Board Appeals for the ICRC Policy*. (A copy of the policy is attached as Appendix A within the materials of this meeting).

Appendix A: Revised Health Professions Appeal and Review Board Appeals Policy

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Health Professions Appeal and Review Board Appeals for ICRC

Type: Policy

Origin Date: March 4, 2016

Section: CD

Approved By Council on: March 4, 2016

Document Number: CD - 130

Next Revision Date: 5 Years After Approval

1.0 POLICY STATEMENT

It is the policy of the College of Respiratory Therapists of Ontario (CRTO) that when the Inquiries, Complaints and Reports Committee (ICRC) releases its Decision and Reasons, any orders rendered by the ICRC will not take effect until **thirty-five (35) days** from the date the parties subject to the Decision are notified.

Furthermore, if the CRTO is notified by parties to the matter that they have requested a review of the Decision by the Health Professions Appeal and Review Board (HPARB), any requirements that a member has been ordered to complete will be placed on hold until HPARB has completed their review and their Decision is released.

This policy does not apply to Acknowledgement and Undertakings between a member and the CRTO, the timelines of which will run in accordance with the terms of such undertakings.

2.0 PURPOSE

The purpose of this policy is to clarify that the orders and timelines issued to a member in a complaint Decision rendered by the ICRC, will be paused to allow for the parties subject to a Decision to file an appeal with HPARB, with the exception of Acknowledgement and Undertakings.

3.0 AUTHORITY & APPLICABILITY

Pursuant to the *Regulated Health Professions Act, 1991* (*RHPA*), being Schedule 2 of the *Health Professions Procedural Code* (the *Code*), under Section 29 (2), the complainant or the member who is the subject of the complaint may request HPARB to review a decision of a panel of the ICRC unless the decision was:

(a) To refer an allegation of professional misconduct or incompetence to the Discipline Committee; or

(b) To refer the member to a panel of the Inquiries, Complaints and Reports Committee under section 58 for incapacity proceedings.

Under section 29 (3) of the *Code*, a request for review may be made only within thirty (30) days after the receipt of the notice of the right to request a review given under clause 27 (1) (c).

4.0 RESPONSIBILITIES

It is the responsibility of CRTO staff to notify the member if the timelines have been impacted by a request for HPARB to review a decision.

5.0 RELATED DOCUMENTS

Section 29(2)(3) of the *Regulated Health Professions Act, 1991 (RHPA)*, being Schedule 2 of the *Health Professions Procedural Code* (the *Code*)

Health Professions Appeal and Review Board Information Sheet

6.0 ABBREVIATIONS

CRTO – College of Respiratory Therapists of Ontario
ICRC – Inquiries, Complaints and Reports Committee
HPARB– Health Professions Appeal and Review Board
RHPA – *Regulated Health Professions Act*

7.0 CONTACT INFORMATION

College of Respiratory Therapists of Ontario
180 Dundas Street West,
Suite 2103
Toronto, ON M5G 1Z8

Telephone: 416-591-7800
Toll-Free (in Ontario): 1-800-261-0528
Fax: 416-591-7890
General Email: questions@crto.on.ca

Answers to Questions
CD-130 HPARB Appeals Policy Consultation 2021
As of: 2/9/2022 12:32:38 PM

Page: About You

Question: Are you a...

Number Who Answered: 4

Respiratory Therapist (including retired)	3	75 %
Other Health Care Professional (including retired)	1	25 %

Question: I live in...

Number Who Answered: 4

Ontario	4	100 %

Page: Questions

Question: CD-130 HPARB Policy Consultation 2021

Number Who Answered: 0

Question: 1. Is the purpose of the Health Professions Appeal and Review Board Appeals policy clear?

Number Who Answered: 3

Yes	No
3	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 2. Do you agree that the Health Professions Appeal and Review Board Appeals policy is clear and understandable?

Number Who Answered: 3

Yes	No
3	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 3. Is the Health Professions Appeal and Review Board Appeals policy free from omissions and/or errors?

Number Who Answered: 3

Yes	No
3	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 4. Does this Health Professions Appeal and Review Board Appeals policy provide you with sufficient understanding of the expectations?

Number Who Answered: 3

Yes	No
3	0
100 %	0 %

Question: If no, please provide further details:
Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?
Number Who Answered: 0

Council Briefing Note

AGENDA ITEM # 4.3 **April 8, 2022**

From:	*Registration Committee*
Topic:	*Revised Entry-to-Practice Competency Assessment Policy*
Purpose:	*For Decision*
Strategic Focus:	*In keeping with the CRTO's mandate, fulfilling the CPMF reporting obligations, and meeting its 2021 – 2025 Strategic Direction, this policy has been revised and refreshed due to the new CRTO Policy Framework.*
Attachment(s):	*Appendix A – Revised Entry-to-Practice Competency Assessment Policy* *Appendix B – Entry-to-Practice Competency Assessment Fact Sheet* *Appendix C – Consultation Survey Results*

PUBLIC INTEREST RATIONALE:
This policy has been revised so that the College of Respiratory Therapists of Ontario (CRTO) meets its mandate of acting in the interest of the public and regulating the profession of Respiratory Therapy by providing a process for applicants who do not meet the registration requirements under paragraph 55(2)(b) of the *Respiratory Therapy Act, 1991*, Part VIII (Registration Regulation).

ISSUE:

The revised Entry-to-Practice Competency Assessment Policy was last approved by Council on December 6, 2019. Due to the new policy framework, this document was updated to the new template. This document has gone through a rigorous policy review process to ensure that all legislative and regulatory requirements have been met.

BACKGROUND:

This policy provides the process for applicants who do not meet the registration requirements under paragraph 55(2)(b) of the Registration Regulation to demonstrate to the Registration Committee that they meet the national standards of competency required for entry-to-practice.

This policy applies to applicants who have graduated from programs offered outside of Canada either in respiratory therapy or in a closely related field; or have graduated from an unapproved Canadian Respiratory Therapy program that is not accredited by Accreditation Canada.

ANALYSIS:

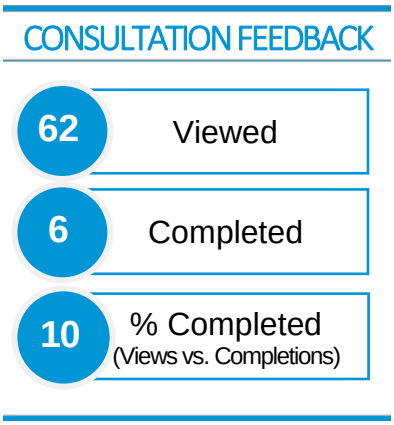
Summary of Changes
Although the format of the policy has been revised, its intent and direction have not changed. The policy has been revised to ensure its relevance to existing registration practices, legislation, and readability, and to incorporate gender-neutral language.

The policy has been condensed to include only the important details regarding the entry-to-practice assessment. Descriptive detail has been removed and transferred to a Fact Sheet (Appendix B).

Public Consultation
The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website, tweeted on the CRTO Twitter account, posted on the Health Profession Regulators of Ontario (HPRO) website, and shared with members in the November bulletin. In total, 62 people viewed the consultation survey, and 6 responses were received (all Respiratory Therapists).

All respondents found the policy clear, understandable, and free from omissions and errors. No comments were received.

For full consultation results see appendix C.



Date consultation opened: November 15, 2021
Length of time consultation was open: 30-days
Date consultation closed: December 15, 2021

RECOMMENDATION:
It is recommended that the CRTO Council approve the Entry-to-Practice Competency Assessment Policy as per the attached motion.

NEXT STEPS:
If the motion is approved, the policy will be posted on the CRTO's website and communicated to members in the next ebulletin.

Council Motion

AGENDA ITEM # 4.3

Motion Title:	*Revised Entry-to-Practice Competency Assessment Policy*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

Council approves the revised *Entry-to-Practice Competency Assessment Policy*. (A copy of the policy is attached as Appendix A within the materials of this meeting).

Appendix A: Revised Entry-to-Practice Competency Assessment Policy

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Entry-to-Practice Competency Assessment

Type: Policy

Origin Date: November 29, 2013

Section: RG

Approved By Council on: December 6, 2019

Document Number: RG-425

Next Revision Date: 5 Years After Approval

1.0 POLICY STATEMENT

The College of Respiratory Therapists of Ontario (CRTO) is responsible for setting the entry-to-practice requirements for respiratory therapists in Ontario. These requirements are set out in the Registration Regulation (*Ontario Regulation 596/94*, Part VIII).

For applicants who are applying for registration with the CRTO and have not graduated from one of the approved respiratory therapy programs[1], they will be required to complete the CRTO's entry-to-practice assessment.

Applicants should refer to the Entry-to-Practice Assessment Factsheet for information regarding the assessment process.

2.0 PURPOSE

The purpose of this policy is to provide a process for applicants who do not meet the registration requirements under paragraph 55(2)(b) of the Registration Regulation to demonstrate to the Registration Committee that they meet the national standards of competencies required for entry-to-practice.

3.0 APPLICABILTY & SCOPE OF POLICY

Applicants who do not meet the registration requirements under paragraph 55(2)(b) of the Registration Regulation are referred to the Entry-to-Practice Assessment process.

Specifically, this policy applies to applicants who have:

[1] See https://www.crto.on.ca/student/registration/accredited-schools/ for a list of approved respiratory therapy programs.

- graduated from programs offered outside Canada either in respiratory therapy or in a closely related field; or
- graduated from an unapproved Canadian Respiratory Therapy program that is not accredited by Accreditation Canada.

4.0 REGISTRATION COMMITTEE REFERRAL

Applicants who have completed the entire Entry-to-Practice Assessment process and have fulfilled all requirements will be referred to a panel of the Registration Committee for consideration and to render a decision. A panel of the Registration Committee will review a comprehensive assessment report prepared by CRTO Registration staff. The comprehensive assessment report will include the results of the educational review, structured interview, and clinical skills assessment.

If the applicant disagrees with a panel of the Registration Committee's decision, they may appeal the decision to the Health Professions Appeal and Review Board (HPARB).

5.0 RELATED DOCUMENTS

- Ontario Regulation 596/94
- Approved Respiratory Therapy Programs
- Entry-to-Practice Assessment Fact Sheet
- Entry to Practice Assessment Appeal Policy
- Document Requirement Policy
- Approved Canadian Program Policy
- Applicant for Registration Guide for Applicants Educated Outside Canada

6.0 CONTACT INFORMATION

College of Respiratory Therapists of Ontario
180 Dundas Street West,
Suite 2103
Toronto, ON M5G 1Z8

Telephone: 416-591-7800
Toll-Free (in Ontario): 1-800-261-0528
Fax: 416-591-7890
General Email: questions@crto.on.ca

Appendix B: Entry-to-Practice Assessment Process Fact Sheet

The Entry-to-Practice Assessment Process Fact Sheet (rG-FS325) can be viewed on the CRTO website at https://www.crto.on.ca/pdf/FactSheets/ETP-Process.FS-325.pdf

Answers to Questions
RG-425 ETP Assessment Policy Consultation 2021
As of: 1/17/2022 3:56:33 PM

Page: Entry-to-Practice Competency Assessment Policy (RG-425) Background

Question: Introduction/Overview

Page: About You

Question: Are you a...

Number Who Answered: 8

Respiratory Therapist (including retired)	8	100 %

Question: I live in...

Number Who Answered: 8

Ontario	8	100 %

Page: Questions

Question: RG-425 Entry-to-Practice Competency Assessment Policy Consultation 2021

Number Who Answered: 0

Question: 1. Is the purpose of the Entry-to-Practice Competency Assessment policy clear?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 2. Do you agree that the Entry-to-Practice Competency Assessment policy is clear and understandable?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 3. Is the Entry-to-Practice Competency Assessment policy free from omissions and/or errors?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 4. Does this Entry-to-Practice Competency Assessment policy provide you with sufficient understanding of the expectations?

Number Who Answered: 6

Yes	No
6	0

100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?

Number Who Answered: 0

Registration Committee Briefing Note

AGENDA ITEM # 4.4 **April 8, 2022**

From:	*Registration Committee*
Topic:	*Revised Entry-to-Practice Competency Assessment Appeal Policy*
Purpose:	*For Decision*
Strategic Focus:	*In keeping with the CRTO's mandate, fulfilling the CPMF reporting obligations, and meeting its 2021 – 2025 Strategic Direction, this policy has been revised and refreshed due to the new CRTO Policy Framework.*
Attachment(s):	*Appendix A – Revised Entry-to-Practice Competency Assessment Appeal Policy* *Appendix B – Consultation Survey Results*

PUBLIC INTEREST RATIONALE:

This policy has been revised so that the College of Respiratory Therapists of Ontario (CRTO) meets its mandate of acting in the interest of the public and regulating the profession of Respiratory Therapy by setting out the appeal criteria if an applicant undergoes the entry-to-practice competency assessment.

ISSUE:

The Entry-to-Practice Competency Assessment Appeal Policy was last approved by Council on June 3, 2016. Due to the new policy framework, this document was updated to the new template. This document has gone through a rigorous policy review process to ensure that all legislative and regulatory requirements have been met.

BACKGROUND:

This policy sets out the process for applicants who have undergone the entry-to-practice assessment process and who wish to appeal any part of the assessment that they believe to be inaccurate.

ANALYSIS:

Summary of Changes

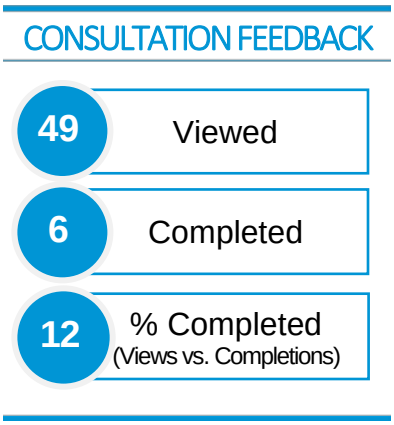
Although the format of the policy has been revised, its intent and direction have not changed. The policy has been revised to ensure its relevance to existing registration practices, legislation, and readability, and to incorporate gender-neutral language.

Public Consultation

The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website, tweeted on the CRTO Twitter account, posted on the Health Profession Regulators of Ontario (HPRO) website, and shared with members in the November bulletin. In total, 49 people viewed the consultation survey, and 6 responses were received (all Respiratory Therapists).

All respondents found the policy clear, understandable, and free from omissions and errors. No comments were received.

For full consultation results see appendix B.



Date consultation opened: November 15, 2021
Length of time consultation was open: 30-days
Date consultation closed: December 15, 2021

RECOMMENDATION:

It is recommended that the CRTO Council approve the revised Entry-to-Practice Competency Assessment Appeal Policy as per the attached motion.

NEXT STEPS:

If the motion is approved, the policy will be posted on the CRTO's website and communicated to members in the next ebulletin.

Council Motion

AGENDA ITEM # 4.4

Motion Title:	*Revised Entry-to-Practice Competency Assessment Appeal Policy*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

Council approves the revised *Entry-to-Practice Competency Assessment Appeal Policy*. (A copy of the policy is attached as Appendix A within the materials of this meeting).

Appendix A: Revised Entry-to-Practice Competency Assessment Appeal Policy

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Entry-to-Practice Competency Assessment Appeal

Type: Policy

Origin Date: June 3, 2016

Section: RG

Approved By Council on: June 3, 2016

Document Number: RG-429

Next Revision Date: 5 Years After Approval

1.0 POLICY STATEMENT

Applicants undergoing the Entry-to-Practice Competency Assessment who believe that the assessment results are inaccurate for any portion of their assessment process may request an appeal within **thirty (30)** days from the date of issue of the Interim Feedback report or the Clinical Skills Assessment (CSA) Gap Report to submit the appeal.

2.0 PURPOSE

The College of Respiratory Therapists of Ontario (CRTO) is committed to ensuring that applicants who undergo the entry-to-practice competency assessment are given the opportunity to review and appeal the results of the Interim Report and the Clinical Skills Assessment Gap Report if they feel the results are inaccurate. This provides applicants with a fair, timely and consistent process to appeal the results of the Interim Report and the CSA Gap Report.

This policy outlines the process for applicants who are undergoing the entry-to-practice assessment process to appeal any part of the assessment that they believe to be inaccurate.

3.0 APPLICABILTY & SCOPE OF POLICY

This policy applies to applicants who are referred to the entry-to-practice assessment process.

APPEAL PROCESS

The assessment process is comprised of three main components: educational review, structured interview, and clinical skills assessment. Applicants receive two reports during the assessment process:

1. Interim Report – The report is provided to applicants after both the educational review and the structured interview are completed. The report lists the assessment results up to that point in the assessment.

2. CSA Gap Report – The report is provided to applicants after the Clinical Skills Assessment stage. The report lists those competency areas where applicants scored below the minimum entry-to-practice standard.

Appeal Process
Applicants who believe that the assessment results for any part of the process are inaccurate may request an appeal.

To start an appeal, applicants must complete and submit the Appeal Template to the Registrar. The request for appeal must be submitted within **thirty (30) days** of receipt of the Interim Report or the CSA Gap report.

With the Appeal Template, applicants must include a detailed description of the issues on which the applicant is basing their appeal. In addition, the request for appeal must include the $250.00 appeal fee (payable to the CRTO by completing a payment form). The fee is refundable if the appeal is resolved in the applicant's favour.

The requests for appeal will be reviewed by an independent appeal panel. The panel will consist of at least two subject matter experts who were not part of the applicant's assessment, and if required, a CRTO staff with expertise in entry-to-practice competencies for respiratory therapy. Applicants will be notified of the outcome of their appeal within **thirty (30) days** of the appeal deadline. The Appeal Panel's decision is final.

4.0 RELATED DOCUMENTS

- Application for Registration Guide for Applicants Educated Outside of Canada
- Appeal Template

5.0 CONTACT INFORMATION

College of Respiratory Therapists of Ontario
180 Dundas Street West,
Suite 2103
Toronto, ON M5G 1Z8

Telephone: 416-591-7800
Toll-Free (in Ontario): 1-800-261-0528
Fax: 416-591-7890
General Email: questions@crto.on.ca

Answers to Questions
RG-429 ETP Appeals Policy Consultation 2021
As of: 1/17/2022 4:07:22 PM

Page: Entry-to-Practice Competency Assessment Appeal Policy (RG-429) Background

Question: Introduction/Overview

Page: About You

Question: Are you a...

Number Who Answered: 6

Respiratory Therapist (including retired)	6	100 %

Question: I live in...

Number Who Answered: 6

Ontario	6	100 %

Page: Questions

Question: RG-429 Entry-to-Practice Competency Assessment Appeal Policy Consultation 2021

Number Who Answered: 0

Question: 1. Is the purpose of the Entry-to-Practice Competency Assessment Appeal policy clear?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 2. Do you agree that the Entry-to-Practice Competency Assessment Appeal policy is clear and understandable?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 3. Is the Entry-to-Practice Competency Assessment Appeal policy free from omissions and/or errors?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 4. Does this Entry-to-Practice Competency Assessment Appeal policy provide you with sufficient understanding of the expectations?

Number Who Answered: 6

Yes	No
6	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?

Number Who Answered: 0

Council Briefing Note

AGENDA ITEM # 4.5 **April 8, 2022**

From:	*Registration Committee*
Topic:	*Revised Labour Mobility Policy: Applicants from Regulated Canadian Jurisdictions*
Purpose:	*For Decision*
Strategic Focus:	*In keeping with the CRTO's mandate, fulfilling the CPMF reporting obligations, and meeting its 2021 – 2025 Strategic Direction, this policy has been revised and refreshed due to the new CRTO Policy Framework.*
Attachment(s):	*Appendix A - Revised Labour Mobility: Applicants from Regulated Canadian Jurisdictions Policy* *Appendix B – Consultation Survey Results*

PUBLIC INTEREST RATIONALE:
This policy has been revised so that the College of Respiratory Therapists of Ontario (CRTO) meets its mandate of acting in the interest of the public and regulating the profession of Respiratory Therapy by setting out the language proficiency requirements for applicants.

ISSUE:
The Labour Mobility Policy was last approved by Council on May 25, 2012. Due to the new policy framework, this document was updated to the new template. This document has gone through a rigorous policy review process to ensure that all legislative and regulatory requirements have been met.

BACKGROUND:

The purpose of this policy is to implement the provisions of the *Ontario Labour Mobility Act* and the *Respiratory Therapy Act, 1991*, Part VIII (Registration Regulation and the Mobility Regulated Canadian Practitioner section(s)iii). The intent of this policy is to promote the mobility and access to employment opportunities of Respiratory Therapists in Canada.

ANALYSIS:

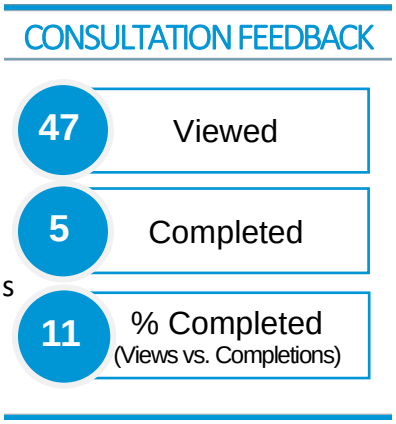
Summary of Changes
Although the format of the policy has been revised, its intent and direction have not changed. The policy has been updated to ensure its relevance to existing registration practices, legislation, and readability, and to incorporate gender-neutral language. There have been no significant changes to the policy.

Public Consultation
The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website, tweeted on the CRTO Twitter account, posted on the Health Profession Regulators of Ontario (HPRO) website, and shared with members in the November bulletin. In total, 47 people viewed the consultation survey, and 5 responses were received (all Respiratory Therapists).

Of those who completed the survey, no comments were received. Although one respondent did not believe the policy provides a sufficient understanding of the expectations, it is important to note that this policy is not meant to be read in isolation.

When shared publicly, the CRTO will ensure that corresponding guides and resources will be provided to Members to ensure that expectations are clear.

For full consultation results see appendix B.



Date consultation opened: November 15, 2021
Length of time consultation was open: 30-days
Date consultation closed: December 15, 2021

RECOMMENDATION:
It is recommended that the CRTO Council approve the revised Labour Mobility: Applicants from Regulated Jurisdictions Policy as per the attached motion.

NEXT STEPS:
If the motion is approved, the policy will be posted on the CRTO's website and communicated to members in the next ebulletin.

Council Motion

AGENDA ITEM # 4.5

Motion Title:	*Revised Labour Mobility: Applicants from Regulated Canadian Jurisdictions Policy*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

Council approves the revised *Labour Mobility: Applicants from Regulated Canadian Jurisdictions Policy* (A copy of the policy is attached as Appendix A within the materials of this meeting).

Appendix A: Labour Mobility: Applicants from Regulated Canadian Jurisdictions Policy

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Labour Mobility: Applicants from Regulated Canadian Jurisdictions

Type: Policy

Origin Date: June 18, 2010

Section: RG

Approved By Council on: May 25, 2012

Document Number: RG-416

Next Revision Date: 5 Years After Approval

1.0 POLICY STATEMENT

Applicants who are applying for registration with the College of Respiratory Therapists of Ontario (CRTO) may apply under the labour mobility provision from regulated Canadian jurisdictions if the applicant:

- holds an out-of-province certificate as defined in section 22.15 of the *Health Professions Procedural Code*[1] that is equivalent to a class of a certificate of registration issued by the CRTO;
- provides a certificate, letter, or other evidence satisfactory to the Registrar that the applicant is in good standing as a respiratory therapist in every jurisdiction where the applicant holds an out-of-province certificate; and
- has practiced the profession there within the past two (2) years.

Subjected to the provisions of section 22.18 of the *Health Professions Procedural Code,* and the measures permitted there, applicants for registration may be deemed to meet the educational, clinical experience and registration examination requirements for that class of certificate.

2.0 PURPOSE

The purpose of this policy is to implement the provisions of the *Ontario Labour Mobility Act, 2009,* and the Registration Regulation under the *Respiratory Therapy Act, 1991,* Part VIII, Mobility - Regulated Canadian Practitioner, Mobility – Graduate Certificate, and to promote the mobility and access to employment opportunities of Respiratory Therapists in Canada.

3.0 APPLICABILTY & SCOPE OF POLICY

[1] The *Health Professions Procedural Code, (the Code)* being Schedule 2 of the *Regulated Health Professions Act, 1991.*

In addition to the conditions listed above in the policy statement section, the CRTO may:

- require the applicant to demonstrate proficiency in English or French if the equivalent language proficiency requirement was not a condition of registration in the host regulatory jurisdiction;
- require an individual to undergo additional training, experience, examinations or assessments if they have **not** practiced the profession in the host jurisdiction within the **two (2)** years preceding the application;
- impose equivalent terms, conditions, and limitations on a certificate of registration to those imposed by the host regulatory body;
- require the applicant to provide evidence of good character;
- require the applicant to obtain professional liability insurance, hold an appropriate immigration status, and not be incapacitated;
- refuse to register the applicant or impose terms, conditions, and limitations on a certificate if such action is deemed necessary to protect the public interest as a result of complaints, or criminal, disciplinary or other proceedings, against the applicant in any jurisdiction whether in or outside Canada, relating to the applicant's competency, conduct or character.

To register with the CRTO under labour mobility provisions, applicants from regulated Canadian jurisdictions must complete and submit an application, together with the applicable fee(s) and documentation to the CRTO. In addition, the CRTO may impose post-registration requirements such as compliance with the Professional Development Program.

4.0 RELATED DOCUMENTS

- Ontario Labour Mobility Act, 2009
- Health Professions Procedural Code (the *Code*)
- Application for Registration Guide for Graduates of Canadian RT Programs or Applicants from Regulated Canadian Jurisdictions
- Applicants from Other Canadian Jurisdictions
- Registration Requirements and How to Meet Them

5.0 CONTACT INFORMATION

College of Respiratory Therapists of Ontario
180 Dundas Street West,
Suite 2103
Toronto, ON M5G 1Z8

Telephone: 416-591-7800
Toll-Free (in Ontario): 1-800-261-0528
Fax: 416-591-7890
General Email: questions@crto.on.ca

Answers to Questions
RG-416 Labour Mobility Policy Consultation 2021
As of: 1/17/2022 2:41:18 PM

Page: Labour Mobility Policy (RG-416) Background

Question: Introduction/Overview

Page: About You

Question: Are you a...

Number Who Answered: 5

Respiratory Therapist (including retired)	5	100 %

Question: I live in...

Number Who Answered: 5

Ontario	4	80 %
Canada, but outside Ontario	1	20 %

Page: Questions

Question: RG-416 Labour Mobility Policy Consultation 2021

Question: 1. Is the purpose of the Labour Mobility policy clear?

Number Who Answered: 5

Yes	No
5	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 2. Do you agree that the Labour Mobility policy is clear and understandable?

Number Who Answered: 5

Yes	No
5	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 3. Is the Labour Mobility policy free from omissions and/or errors?

Number Who Answered: 4

Yes	No
4	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 4. Does this Labour Mobility policy provide you with sufficient understanding of the expectations?

Number Who Answered: 5

Yes	No
4	1

80 %	20 %

Question: If no, please provide further details:

Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?

Number Who Answered: 0

Council Briefing Note

AGENDA ITEM # 4.6 **April 8, 2022**

From:	*Registration Committee*
Topic:	*Revised Language Proficiency Requirements Policy*
Purpose:	*For Decision*
Strategic Focus:	*In keeping with the CRTO's mandate, fulfilling the CPMF reporting obligations, and meeting its 2021 – 2025 Strategic Direction, this policy has been revised and refreshed due to the new CRTO Policy Framework.*
Attachment(s):	*Appendix A – Revised Language Proficiency Requirements Policy* *Appendix B – Consultation Survey Results*

PUBLIC INTEREST RATIONALE:
This policy has been revised so that the College of Respiratory Therapists of Ontario (CRTO) meets its mandate of acting in the interest of the public and regulating the profession of Respiratory Therapy pursuant to the *Ontario Labour Mobility Act* and Registration Regulation *(Part VIII, Respiratory Therapy Act, 1991)*.

ISSUE:
The Language Proficiency Requirements Policy was last approved by Council on May 25, 2012. Due to the new policy framework, this document was updated to the new template. There were no significant changes to the policy.

BACKGROUND:
This policy outlines the accepted English and French language proficiency test scores for applicants for registration.

This policy is aligned with the CRTO's mandate of protecting the public and regulating the profession through being transparent and setting language proficiency requirements for registration.

Minor changes to this policy were made by staff on July 14, 2021, to reflect changes to the administration of the CanTEST and TESTcan. As of August 15, 2021, the University of Ottawa no longer administers language proficiency tests. As a result, test scores by CanTEST and TESTcan will no longer be valid after August 15, 2022, and the policy was revised to reflect this.

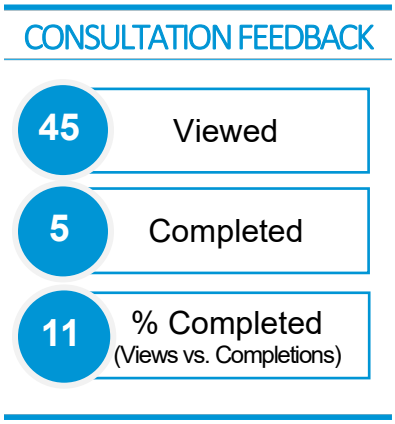
ANALYSIS:

Summary of Changes
The policy has been revised for its readability and to incorporate gender-neutral language. The format of the policy has been revised, however, the intent of the policy and the required English and French language proficiency test scores and providers have not changed.

Public Consultation
The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website, tweeted on the CRTO Twitter account, posted on the Health Profession Regulators of Ontario (HPRO) website, and shared with members in the November bulletin. In total, 45 people viewed the consultation survey, and 5 responses were received (all Respiratory Therapists).

All respondents found the policy clear, understandable, and free from omissions and errors. No comments were received.

For full consultation results see appendix B.



Date consultation opened: November 15, 2021
Length of time consultation was open: 30-days
Date consultation closed: December 15, 2021

RECOMMENDATION:
It is recommended that the CRTO Council approve the revised Language Proficiency Requirements Policy as per the attached motion.

NEXT STEPS:
If the motion is approved, the policy will be posted on the CRTO's website and communicated to members in the next ebulletin.

Council Motion

AGENDA ITEM # 4.6

Motion Title:	*Revised Language Proficiency Requirements Policy*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

Council approves the revised *Language Proficiency Requirements Policy* (A copy of the policy is attached as Appendix A within the materials of this meeting).

Appendix A: Language Proficiency Requirements Policy

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Language Proficiency Requirements

Type: Policy

Origin Date: September 22, 2006

Section: RG

Approved By Council on: May 25, 2012

Document Number: 407

Next Revision Date: 5 Years After Approval

1.0 POLICY STATEMENT

Applicants for registration whose first language is not in English or French and their relevant health-care education/instruction was not in English or French must demonstrate fluency in either language.

2.0 PURPOSE

This policy sets out the accepted English and French language proficiency test scores for registration with the College of Respiratory Therapists of Ontario (CRTO).

3.0 APPLICABILTY & SCOPE OF POLICY

Applicants looking to demonstrate their ability to communicate fluently in either English or French will need to submit one of the following approved test scores.

a. ACCEPTED LANGUAGE PROFICIENCY TESTS

An applicant for registration must submit a copy of their test score report with their initial application for registration. The applicant is responsible for the cost of the language proficiency test.

b. ENGLISH LANGUAGE PROFICIENCY TEST SCORES

CanTEST (results will only be accepted until August 15, 2022)				
Reading	Writing	Listening	Speaking	Overall
4.5	**4.0**	**5.0**	**4.5**	**5.0**
International English Language Testing System (IELTS) Academic (AC) or General Training (GT)				

Reading	Writing	Listening	Speaking	Overall
7	**7**	**7**	**7**	**7**
Michener English Language Assessment (MELA)				
Reading	Writing	Listening	Speaking	Overall
8	**8**	**9**	**9**	**N/A**
Test of English as a Foreign Language (TOEFL) iBT				
Reading	Writing	Listening	Speaking	Overall
22	**20**	**24**	**24**	**90**
Canadian Academic English Language Test (CAEL)				
Reading	Writing	Listening	Speaking	Overall
70	**70**	**80**	**70**	**70**

These scores are the minimum benchmark scores that must be achieved by applicants.

c. FRENCH LANGUAGE PROFICIENCY TEST SCORES

TESTCan (results will only be accepted until August 15, 2022)				
Reading	Writing	Listening	Speaking	Overall
4.5	**4.0**	**5.0**	**4.5**	**5.0**
Test d'évaluation de français (TEF)				
Reading	Writing	Listening	Speaking	Overall
N/A	**N/A**	**N/A**	**N/A**	**5**
Test de français international (TFI)				
Reading/Writing		Listening/Speaking		Overall
400		**410**		**810**

These scores are the minimum benchmark scores that must be achieved by applicants

4.0 RELATED DOCUMENTS/WEBSITE LINKS

- CanTEST - www.cantest.uottawa.ca/index.php
- International English Language Testing System (IELTS) - www.ielts.org/default.aspx
- Michener English Language Assessment (MELA) - www.themela.com
- Test of English as a Foreign Language (TOEFL) iBT - www.ets.org/toefl
- Canadian Academic English Language Test (CAEL) - www.cael.ca
- TESTCan - www.testcan.uottawa.ca

- Test d'évaluation de français (TEF) - https://www.lefrancaisdesaffaires.fr/
- Test de français international (TFI) - https://www.ets.org/tfi

5.0 CONTACT INFORMATION

College of Respiratory Therapists of Ontario
180 Dundas Street West,
Suite 2103
Toronto, ON M5G 1Z8

Telephone: 416-591-7800
Toll-Free (in Ontario): 1-800-261-0528
Fax: 416-591-7890
General Email: questions@crto.on.ca

Answers to Questions
RG-407 Language Proficency Requirements Policy Consultation 2021
As of: 1/17/2022 1:22:54 PM

Page: Language Proficiency Requirements Policy (RG-407) Background

Question: Introduction/Overview

Page: About You

Question: Are you a...

Number Who Answered: 5

Respiratory Therapist (including retired)	5	100 %

Question: I live in...

Number Who Answered: 5

Ontario	5	100 %

Page: Questions

Question: RG-407 Language Proficiency Requirements Policy Consultation 2021

Question: 1. Is the purpose of the Language Proficiency Requirements policy clear?

Number Who Answered: 5

Yes	No
5	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 2. Do you agree that the Language Proficiency Requirements policy is clear and understandable?

Number Who Answered: 5

Yes	No
5	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 3. Is the Language Proficiency Requirements policy free from omissions and/or errors?

Number Who Answered: 4

Yes	No
4	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 4. Does this Language Proficiency Requirements policy provide you with sufficient understanding of the expectations?

Number Who Answered: 5

Yes	No
5	0
100 %	0 %

Question: If no, please provide further details:
Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?
Number Who Answered: 0

Council Briefing Note

AGENDA ITEM # 4.7 **April 8, 2022**

From:	*Registration Committee*
Topic:	*Revised Registration Currency Policy*
Purpose:	*For Decision*
Strategic Focus:	*In keeping with the CRTO's mandate, fulfilling the CPMF reporting obligations, and meeting its 2021 – 2025 Strategic Direction, this policy has been revised and refreshed due to the new CRTO Policy Framework.*
Attachment(s):	*Appendix A – Registration Currency Policy* *Appendix B – Registration Currency Procedure* *Appendix C – Consultation Survey Results*

PUBLIC INTEREST RATIONALE:
This policy has been revised to better support the Registration Committee of the College of Respiratory Therapists of Ontario (CRTO) to determine whether it is in the public interest to approve an application for registration, or reinstatement when the applicant does not satisfy the registration requirements.

ISSUE:
The Registration Currency Policy was last approved by Council on September 21, 2018. Due to the new policy framework this document was updated to the new template. This document has gone through a rigorous policy review process to ensure that all legislative and regulatory requirements have been met.

BACKGROUND:
This policy sets out the considerations that may be used by the Registration Committee to determine whether it is in the public interest to approve an application for registration or reinstatement when the applicant does not satisfy the registration requirements under section 55(5) or 58(3) of the *Respiratory Therapy Act, 1991* (ON. Reg. 596/94, PART VIII, Registration), and if so, whether a term, condition, or limitation should be imposed on the certificate of registration.

ANALYSIS:

Summary of Changes
Although the policy has been revised, it is important to note that no changes were made to the intent or the direction of the original policy. The policy has been updated to ensure its relevance to existing registration practices, legislation, and reability, and to incorporate gender-neutral language.

Specific changes have been made to the descriptions of the terms, conditions, and limitations that can be imposed on a certificate of registration. The changes were made to provide clarity on the interpretation of the Certification Programs for Advanced Prescribed Procedures Below the Dermis Professional Practice Guideline and are noted in the policy (see the tracked changed in the policy).

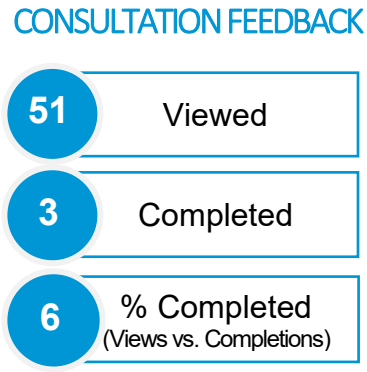
The policy that went out for consultation included details under section 1.0 Policy Statement which was a reiteration of the *Respiratory Therapy Act, 1991*. This detail was removed from what was originally brough forward for public consultation, to align with the principles of the CRTO's policy framework.

Public Consultation
The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website, tweeted on the CRTO Twitter account, posted on the Health Profession Regulators of Ontario (HPRO) website and shared with members in the November bulletin. In total, 51 people viewed the consultation survey, and 3 responses were received (all Respiratory Therapists).

All respondents found the policy clear, understandable, and free from omissions and errors. No comments were received.

For full consultation results see appendix C.

Date consultation opened: November 15, 2021
Length of time consultation was open: 30-days
Date consultation closed: December 15, 2021



RECOMMENDATION:
It is recommended that the CRTO Council approve the revised Registration Currency Policy as per the attached motion.

NEXT STEPS:
If the motion is approved, the policy will be posted on the CRTO's website and communicated to members in the next ebulletin.

Council Motion

AGENDA ITEM # 4.7

Motion Title:	*Registration Currency Policy*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

Council approves the revised *Registration Currency Policy* (A copy of the policy is attached as Appendix A within the materials of this meeting).

Appendix A: Registration Currency Policy

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Registration Currency

Type: Policy

Origin Date: June 20, 2008

Section: RG

Approved By Council on: September 21, 2018

Document Number: 410

Next Revision Date: 5 Years After Approval

1.0 POLICY STATEMENT

The College of Respiratory Therapists of Ontario (CRTO) is responsible for setting Respiratory Therapy entry-to-practice requirements in the province of Ontario in the public interest.

Applicants for registration who do not meet the currency requirement under section 55(5) or 58 (3) of the *Ontario Regulation 596/94*, Part VIII (Registration Regulation) will be referred by the Registrar to a Panel of the Registration Committee for consideration. The criteria and processes that may be used by the Registration Committee are outlined below.

2.0 PURPOSE

This policy sets out the considerations that may be used by the Registration Committee to determine whether it is in the public interest to approve an application for registration when the applicant does not satisfy the registration requirements under section 55(5) or 58(3) of the Registration Regulation, and if so, whether a term, condition, or limitation should be imposed on the certificate of registration.

If a term, condition, or limitation is to be applied to a certificate of registration, this policy sets the minimum requirements and restrictions for a certificate of registration of an applicant who does not meet the currency requirement.

3.0 APPLICABILITY AND SCOPE

General and Graduate Certificate of Registration

This policy applies to applicants for registration for a General Certificate of Registration or a Graduate Certificate of Registration where the applicant does not meet the requirements under section 55(5) or 58(3) of the Registration Regulation.

Reinstatement of an Inactive Certificate of Registration:
Applicants who are seeking to reinstate their license from an Inactive Certificate of Registration and does not meet the registration requirement under section 55(5) or 58(3) of the Registration Regulation will be referred to a panel of the Registration Committee, and the panel will refer to this policy as a guide when considering reinstatement applications.

CONSIDERATION

Applicants referred to a panel of the Registration Committee will be considered on a case-by-case basis, taking into consideration a number of factors:

1. Years since graduated from an approved Respiratory Therapy program
2. Time and duration of last practice
3. Nature and intensity of last practice
4. Quality and quantity of efforts to maintain currency while not practising
5. The applicant's re-entry plan
6. Results of an entry-to-practice assessment

MINIMUM REQUIREMENTS AND RESTRICTIONS

General Certificate of Registration	Years since practice		
Requirements:	**2 - 5**	**5 - 10**	**10+**
The applicant may be asked to provide evidence of refresher/retraining to demonstrate readiness to practise Respiratory Therapy before being granted a certificate of registration.	✓	✓	✓
Conditions to be imposed on the certificate of registration (issued for a limited period)			
1. The member shall, at the first reasonable opportunity, advise every employer of any terms, conditions and limitations that apply to the m~~M~~ember's certificate of registration if their employment is in the field of respiratory therapy.	✓	✓	✓
2. The member shall only perform a controlled act that is authorized to the profession if it is performed under the **general supervision** of a Member of a College within the meaning of the *Regulated Health Professions Act, 1991* who, is authorized to perform the controlled act and is competent to do so and who is available to be personally present at the site where the authorized act is performed on ten (10) minutes notice.	✓		
3. The member shall only perform a controlled act authorized to Respiratory Therapy, to gain ~~for the purpose of gaining~~ competence in that procedure and only if performed under the **direct supervision** of a regulated health professional who is authorized to perform the controlled act.		✓	✓

4. The member shall only ~~not~~ perform advanced prescribed procedures below the dermis, for the purpose of gaining competence and only if performed under the **direct supervision** of a regulated health professional who is authorized to perform who is authorized to perform advanced prescribed procedures.~~.~~	✓	✓	✓
5. The member shall only ~~not~~ perform a tracheostomy tube change for a stoma that is more than 24 hours old, to gain ~~for the purpose of gaining~~ competence in that procedure, and only if performed under the **direct supervision** of a regulated health professional who is authorized to perform the controlled act.		✓	✓
6. The member shall only ~~not~~ perform a tracheostomy tube change for a stoma that is less than 24 hours old, to gain ~~for the purpose of gaining~~ competence in that procedure and only~~-~~ if performed under the **direct supervision** of a regulated health professional who is authorized to perform the controlled act.	✓	✓	✓
7. The member shall not delegate a controlled act.	✓	✓	✓
8. The member shall not accept delegation for any controlled act.	✓	✓	✓
9. The member is required to cooperate with a Quality Assurance Committee peer and practice assessment of ~~his/her~~their knowledge, skills, and judgment (using the Launch RT Jurisprudence Assessment), within three (3) months of receiving ~~his/her~~their certificate of registration and must comply with any remediation ordered as a result of that assessment.	✓	✓	✓
10. The member is required to submit to the Quality Assurance Committee their~~his/her~~ records of continuous quality improvement activities (utilizing the PORTfolio^{OM}) by their assigned Review Year deadline.	✓	✓	✓
* Applicants for **General Certificate of Registration** who have not practised as Respiratory Therapists in **the ten years** preceding their application will be asked to provide evidence of refresher/retraining to demonstrate readiness to practise Respiratory Therapy prior to being granted a certificate of registration.			

Graduate Certificate of Registration	**Years since practice**	
Requirements	**2 - 5**	**5+**
The applicant may be asked to provide evidence of refresher/ retraining to demonstrate readiness to practise Respiratory Therapy before being granted a certificate of registration.	✓	✓*
Conditions to be imposed on the certificate of registration (issued for a limited period)		

1. The member shall, at the first reasonable opportunity, advise every employer of any terms, conditions and limitations that apply to the ~~M~~member's certificate of registration if their employment is in the field of respiratory therapy.	✓	✓
2. The member shall only perform a controlled act, authorized to Respiratory Therapy, to gain ~~for the purpose of gaining~~ competence in that procedure and only if performed under the **direct supervision** of a regulated health professional who is authorized to perform the controlled act.	✓	✓
3. The member shall not perform advanced prescribed procedures below the dermis.	✓	✓
4. The member shall not perform authorized act #5 "administering a prescribed substance by inhalation".	✓	✓
5. The member shall only perform a tracheostomy tube change for a stoma that is more than 24 hours old, to gain ~~for the purpose of gaining~~ competence in that procedure and only if under the **direct supervision** of a regulated health professional who is authorized to perform the controlled act.	✓	✓
6. The member shall not perform a tracheostomy tube change for a stoma that is less than 24 hours old.	✓	✓
7. The member shall not delegate a controlled act.	✓	✓
8. The member shall not accept delegation for any controlled act.	✓	✓
9. The member is required to cooperate with a Quality Assurance Committee peer and practice assessment of ~~his/her~~their knowledge, skills, and judgment (using the Launch RT Jurisprudence Assessment), within three (3) months of receiving ~~his/her~~their certificate of registration and must comply with any remediation ordered as a result of that assessment.	✓	✓
10. The member is required to submit to the Quality Assurance Committee ~~his/her~~ their records of continuous quality improvement activities (utilizing the PORTfolio^{OM}) by their assigned Review Year deadline.	✓	✓
A graduate certificate is deemed to have been revoked eighteen (18) months after its (initial) date of issue.	✓	✓
* Applicants for **Graduate Certificate of Registration** who have not practised as Respiratory Therapists in **the five years** preceding their application will be asked to provide evidence of refresher/retraining to demonstrate readiness to practise Respiratory Therapy before being granted a certificate of registration.		

4.0 RELATED DOCUMENTS

- Currency Guide.pdf (crto.on.ca)
- Guide for Terms, Conditions, and Limitations imposed by the Registration Committee
- Application to Change Terms, Conditions and Limitations
- Interpretation of Authorized Acts Professional Practice Guideline (PPG) (crto.on.ca)

5.0 CONTACT INFORMATION

College of Respiratory Therapists of Ontario
180 Dundas Street West
Suite 2103
Toronto, ON M5G 1Z8
Canada

Telephone: 416-591-7800
Toll-Free (in Ontario): 1-800-261-0528
Fax: 416-591-7890
General Email: questions@crto.on.ca

Appendix B: Registration Currency Procedure

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO		
	**Registration Currency**	
	Type: Procedure	**Origin Date:** June 3, 2016
	Section: RG	**Approved On:** November 8, 2019
	Document Number: 410	**Next Revision Date:** 5 Years After Approval

BACKGROUND

Most applicants for registration with the College of Respiratory Therapists of Ontario (the "CRTO") are approved as a matter of routine (i.e., their application meets all the registration requirements).

When an applicant does not meet the registration requirements, the Registrar can either:

1. Refer the application to the Registration Committee (RC), or
2. Obtain the consent of the applicant to issue a certificate of registration with terms conditions, or limitations (with approval of an RC Panel).

The Currency Policy sets out the criteria that may be used by the RC to determine if it is in the public interest to approve an application for registration when the applicant does not satisfy the two-year currency requirement under section *55(5) or 58(3) of the Respiratory Therapy Act, 1991* (Part VIII, Registration, ON. Reg. 596/94), and if so, whether a term, condition, or limitation should be imposed on the certificate of registration.

OBJECTIVE

This procedure outlines the considerations that the Registration Committee may make when reviewing an application for reinstatement or registration when the applicant does not meet the currency requirement in the registration regulation.

CONSIDERATIONS

1. **Referrals to an RC Panel:**
   When an applicant[1] for registration does not meet the two-year currency requirement, the Registrar may do one or more of the following:

[1] "Applicant" refers to both applicant for initial registration and to an Inactive member applying for reinstatement

a) Refer the application to a panel of the Registration Committee. Applicants referred to the RC will have **thirty (30)** days to make any submission. In addition, applicants will be asked to complete sections 1 to 5 of the Currency Guide.

I. Panel Considerations:
After thirty (30) days, and within a reasonable timeframe, the RC will convene a panel to consider the application for registration. A panel of the RC will consider if it is in the public interest to direct the Registrar to issue a certificate of registration, and if so, whether to issue the certificate with terms, conditions, or limitations. To arrive at their decision, the panel may consider:

- All current written submissions by the applicant;
- Applicant's employment history;
- The area(s) of practice the applicant would like to work in, and
- Other relevant information.

II. Decision Guidelines:
Decisions will be made based on the applicant's specific personal circumstances; however, panels will be assisted by the general minimum requirements and restrictions outlined in the Currency Policy. A written order and reasons will be provided to the applicant under section 20(1) of the *Health Professions Procedure Code*.

b) **Negotiate to obtain the applicant's consent to terms, conditions, and limitations** (TCLs) as outlined in the Currency Policy, when:

I. The applicant is registered with an Inactive Certificate of Registration
II. The currency gap is not greater than three years, and
III. The applicant has some RT practice experience.

The offer to register the applicant with TCLs will be based on the criteria outlined in the Currency Policy and be consistent with previous RC decisions. If the applicant agrees to the proposed TCLs, the Registrar will forward the information to the RC for approval. If a panel of the RC gives its approval, a certificate of registration will be issued when the applicant submits the applicable registration fees.

2. Referral to a Panel of the Quality Assurance Committee (QAC)

a) Where the RC directs the applicant to cooperate with a QAC peer and practice assessment of their knowledge, skills, and judgment (using the Launch RT Jurisprudence Assessment), the applicant will be required to complete the assessment within **three (3)** months of receiving their certificate of registration.

b) Where the RC directs the applicant to submit to the QAC their records of continuous quality improvement activities (utilizing the PORTfolio^{OM}), the applicant will be required to submit the Portfolio^{OM} by their assigned Review Year deadline (as determined by the Quality Practice Staff).

In the interest of expediting the process in a timely manner, Quality Practice Staff will contact the applicant who has been directed to complete the QA requirements as listed above and notify them of the procedure.

The report of the Applicant's Launch RT Jurisprudence Assessment results and PORTfolio^{OM} review will be evaluated by the QAC. Should the results be unsatisfactory, the QAC will generally follow the standard process of mentoring and/or remediation.

CONTACT INFORMATION

Lisa Ng, Manager of Registration
ng@crto.on.ca
416-591-7800 ext. 25

RELATED DOCUMENTS

- Currency Policy
- Currency Guide
- Professional Development Policy
- Professional Development Program Procedure

Answers to Questions
RG-410 Registration Currency Policy Consultation 2021
As of: 1/17/2022 2:22:07 PM

Page: Registration Currency Policy (RG-410) Background

Question: Introduction/Overview

Page: About You

Question: Are you a...

Number Who Answered: 3

Respiratory Therapist (including retired)	3	100 %

Question: I live in...

Number Who Answered: 3

Ontario	3	100 %

Page: Questions

Question: RG-410 Registration Currency Policy Consultation 2021

Question: 1. Is the purpose of the Registration Currency policy clear?

Number Who Answered: 3

Yes	No
3	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 2. Do you agree that the Registration Currency policy is clear and understandable?

Number Who Answered: 3

Yes	No
3	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 3. Is the Registration Currency policy free from omissions and/or errors?

Number Who Answered: 2

Yes	No
2	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 4. Does this Registration Currency policy provide you with sufficient understanding of the expectations?

Number Who Answered: 3

Yes	No
3	0
100 %	0 %

Question: If no, please provide further details:
Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?
Number Who Answered: 0

Council Briefing Note

AGENDA ITEM # 4.8 **April 8, 2022**

From:	*Kelly Arndt, RRT, Manger, Quality Practice*
Topic:	***Draft Professional Development Program (PDP) Policy***
Purpose:	*For Decision*
Strategic Focus:	*Protecting patient safety by ensuring that Respiratory Therapists understand their professional responsibilities*
Attachment(s):	Appendix A – *New policy* Appendix B – *Consultation survey results*

PUBLIC INTEREST RATIONALE:
This policy enables Respiratory Therapists in Ontario to understand the expectations and professional responsibilities set out by the CRTO regarding the Professional Development Program. This policy will help to enhance the understanding of the role that Respiratory Therapists (RTs) must carry out to ensure public and patient safety.

ISSUE:
The Professional Development Program Policy was previously reviewed by the QA Committee in 2020 and approved at Council on May 29, 2020. Since then, this document has gone through a rigorous policy review process based on a new policy framework. It has been updated to reflect the CRTO's new policy template. While the CRTO's PDP program and requirements have not changed, this Policy outlines the specific requirements and has been revised to be more concise.

BACKGROUND:
This policy sets direction and outlines the requirements of members in the ongoing requirement of professional development in their practice. It is the CRTOs mandate to act in the public interest by supporting RTs in their professional development. This policy facilitates member's successful completion of the PDP program.

ANALYSIS:

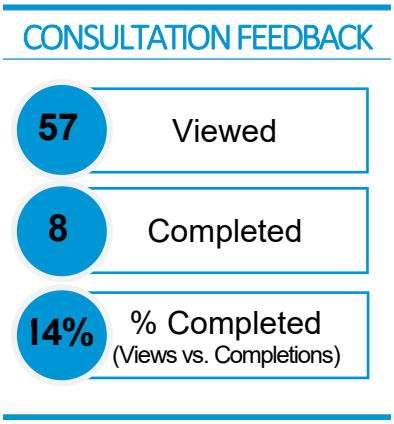
Summary of Changes
Although the policy has been revised to be more concise, its intent and direction remain the same. The explanatory detail that was in the previous policy has been transferred to the Professional Development section of the website so that the information is still readily available.

Public Consultation
The document was posted according to the CRTO's public consultation process. A consultation survey was posted on the CRTO's website, tweeted on the CRTO Twitter account, posted on the Health Profession Regulators of Ontario (HPRO) website and shared with members in the November bulletin. In total, 57 people viewed the consultation survey, and 8 responses were received (all Respiratory Therapists).

There were no comments received and no changes were made to the PDP Policy as a result of this feedback.

For full consultation results see appendix B.

Date consultation opened: November 15, 2021
Length of time consultation was open: 30-days
Date consultation closed: December 15, 2021



RECOMMENDATION:

It is recommended that Council approve the Professional Development Program (PDP) Policy as per the Motion.

NEXT STEPS:

If the motion is approved the policy will be translated, and published on the CRTO's website.

Council Motion

AGENDA ITEM # 4.8

Motion Title:	*Professional Development Policy*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

The Council approve the *Professional Development Policy.* (A copy is attached as Appendix *A* to this motion).

Appendix A: Professional Development Program Policy

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Professional Development Program

Type: Policy

Origin Date: May 27, 2011

Section: QA

Approved by Council: May 29, 2020

Document Number: QA-101

Next Revision Date: 5 Years After Approval

1.0 POLICY STATEMENT

The CRTO Professional Development Program (PDP) consists of the following components:

- Launch RT Jurisprudence Assessment;
- RelevanT eLearning Module;
- Portfolio Online for Respiratory Therapists (PORTfolio^{OM});
- Specific Continuing Education or Remediation Program (SCERP); and
- Practice Assessment.

A description of each component is listed below.

2.0 PURPOSE

It is our policy to uphold the College of Respiratory Therapists of Ontario's (CRTO's) mandate to act in the public interest by supporting the ongoing professional development of Ontario Respiratory Therapists (RTs). The purpose of this policy is to facilitate CRTO member's successful completion of the components of the Professional Development Program which is designed to:

- promote continuing competence and continuing quality improvement;
- promote interprofessional collaboration; and
- address changes in practice environments, standards of practice, and entry-to-practice competencies, as well as advances in technology.

3.0 APPLICABILTY

This policy applies to all members of the CRTO, which includes members registered with General, Limited, Graduate or Inactive Certificates of Registration.

4.0 RESPONSIBILITIES

CRTO Members

Launch RT Jurisprudence Assessment

All new and reinstated CRTO members, regardless of route of entry to practice, must complete the Launch RT Jurisprudence Assessment within three (3) months of registration. Launch RT Jurisprudence Assessment is designed to assess members' knowledge, skill, and judgment and requires a passing mark of 70%. Deferrals for the Launch RT Jurisprudence Assessment will only be granted by the QAC in extenuating circumstances.

More information on the deferral process is available in the Deferral of Professional Development Program Requirements Policy.

RelevanT eLearning Module

All CRTO members must complete the RelevanT Learning Module on an annual basis, which provides information about practice standard changes. It is not a pass/fail module, rather completion only. In order to successfully complete the RelevanT module, each member is required to correctly answer all of the questions in the module. Members are permitted to attempt the questions as many times as necessary in order to correctly answer all of them. Deferrals are not granted for the RelevanT eLearning Module.

PORTfolio^{OM}

All CRTO members must maintain their PORTfolio on an ongoing basis. CRTO members with General, Limited and Graduate Certificates of Registration are required to submit their PORTfolio online, using the PDKeepr module, during their predefined Review Year. Review Years are available on a member's CRTO webpage and are on a five year cycle. Members registered with Inactive Certificates of Registration are not required to submit their PORTfolio. Deferrals for PORTfolio submissions will only be granted by the QAC in extenuating circumstances.

More information on the deferral process is available in the Deferral of Professional Development Program Requirements Policy.

Specific Continuing Education or Remediation Program (SCERP)

CRTO members whose knowledge, skill, and judgment have been assessed and found to be unsatisfactory may be directed by the Quality Assurance Committee (QAC) to participate in a Specified Continued Education or Remediation Program (SCERP). This remediation process is intended to be an educational opportunity for the member to improve their knowledge, skill, and judgment.

The form and nature of the SCERP will depend on the member's identified learning needs and challenges and may take the form of:

- A customized educational tool that is implemented utilizing a mentor;
- An existing course or educational program; or
- Another educational tool that is appropriate for the Member's learning needs.

There are three (3) circumstances where a member may be required to undergo a SCERP:

1. If a member receives a score below 70% on two consecutive attempts at the Launch RT Jurisprudence Assessment; and/or
2. If a member submits two consecutive PORTfolios that are determined to not meet the requisite criteria for successful completion; and/or
3. If a member has completed a practice assessment and found to have unsatisfactory knowledge, skill, and judgment. In these instances, the member will be referred to a panel of the QAC.

Practice Assessment

The Regulated Health Professions Act requires that all health regulatory Colleges have a Quality Assurance Program that consists of self, peer, and practice assessments. A CRTO member may be selected by the QAC to undergo peer and practice assessments to determine whether the members' knowledge, skill and judgment are satisfactory. A Practice Assessment may also be required for reasons including but not limited to criteria specified by the Committee. One such criteria specified by the QAC is that new CRTO Members who have not graduated from an approved Canadian program shall be required to complete a Practice Assessment as outline in the CRTO's Entry-to-Practice Competency Assessment Policy.

More information on the deferral process is available in the Deferral of Professional Development Program Requirements Policy.

5.0 AUTHORITY & MONITORING

This policy is in alignment with section 80 of the *Health Professions Procedural Code* (the *Code)* being Schedule 2 to the *Regulated Health Professions Act, 1991,* (*RHPA*) and *Ontario Regulation O. Reg. 379/12: General (Part VI - Quality Assurance)*.

6.0 CONSEQUENCES FOR NON-COMPLIANCE

The CRTO establishes timelines for completion of all PDP components, criteria for successful completion and monitors participation of CRTO Members in the PDP on an ongoing basis. If a CRTO Member does not complete their PDP requirements within the established timelines, (See Summary of Non-Compliance and Late Submission of PDP Requirements in Appendix A), a panel of the QA Committee may do any one or more of the following:

- require the Member to undergo a peer and practice assessment; and/or
- disclose the name of the Member and allegations against the Member to the Inquiries, Complaints and Reports Committee (ICRC) if the QAC is of the opinion that the Member may have committed an act of professional misconduct or may be incompetent or incapacitated.

7.0 RELATED DOCUMENTS

- CRTO Professional Development Program (PDP)
- Deferral of Professional Development Program Requirements Policy
- PDP Peer Assessors, Mentors, Practice Assessors Policy
- Section 80 of the *Health Professions Procedural Code* (the *Code)* being Schedule 2 to the *Regulated Health Professions Act, 1991, (RHPA)*
- *Ontario Regulation O. Reg. 379/12: General (Part VI - Quality Assurance)*

8.0 APPENDICIES

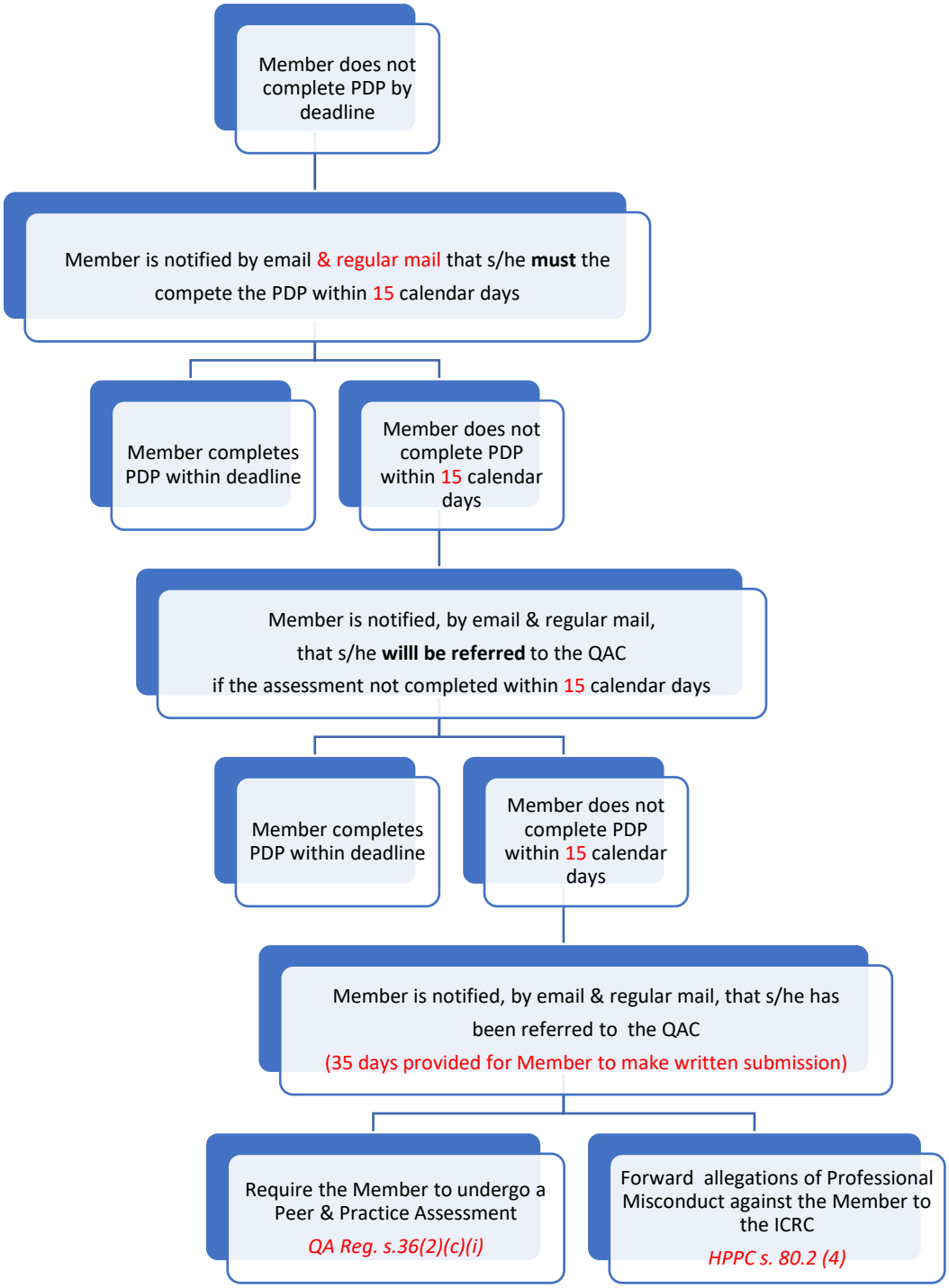
Appendix A - Summary of Non-Compliance & Late Submission of PDP Requirements

9.0 CONTACT INFORMATION

College of Respiratory Therapists of Ontario
180 Dundas Street West,
Suite 2103
Toronto, ON M5G 1Z8

Telephone: 416-591-7800
Toll-Free (in Ontario): 1-800-261-0528
Fax: 416-591-7890
General Email: questions@crto.on.ca

APPENDIX A - Summary of Non-Compliance & Late Submission of PDP Requirements



Answers to Questions
QA-101 PDP Policy Consultation 2021
As of: 1/5/2022 1:37:10 PM

Page: Professional Development Program Policy (QA-101) Background

Question: Introduction/Overview

Number Who Answered: 0

Page: About You

Question: Are you a...

Number Who Answered: 8

Respiratory Therapist (including retired)	8	100 %

Question: I live in...

Number Who Answered: 8

Ontario	8	100 %

Page: Questions

Question: QA-101 Professional Development Program Policy Consultation 2021

Number Who Answered: 0

Question: 1. Is the purpose of the Professional Development Program policy clear?

Number Who Answered: 7

Yes	No
6	1
86 %	14 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 2. Do you agree that the Professional Development Program policy is clear and understandable?

Number Who Answered: 7

Yes	No
6	1
86 %	14 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 3. Is the Professional Development Program policy free from omissions and/or errors?

Number Who Answered: 6

Yes	No
4	2
67 %	33 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: 4. Does this Professional Development Program policy provide you with sufficient understanding of the expectations?

Number Who Answered: 7

Yes	No
6	1
86 %	14 %

Question: If no, please provide further details:
Number Who Answered: 0

Page: Additional Comments

Question: Do you have any additional comments you would like to share?
Number Who Answered: 0

Council Briefing Note

AGENDA ITEM # 4.9 **April 8, 2022**

From:	*Carole Hamp, RRT, Registrar & CEO*
Topic:	*Policies Being Rescinded & Archived*
Purpose:	*For Decision*
Strategic Focus:	*That the CRTO meets and fulfills its Mission Statement and remains current with legislation, Member's obligations, and the publics expectations*
Attachment(s):	*Appendix A: Appointment of Non-Council Committee Members Policy* *Appendix B: Election Process - Executive Committee Policy* *Appendix C: In Camera Council Meeting Policy* *Appendix D: Responsibilities Committee Chairs Policy* *Appendix E: Code of Conduct for Council Members and Non-Council Members of Committees Policy* *Appendix F: Appointment of Committee Chairs and Vice-Chairs Policy* *Appendix G: Change of Name Requests Policy* *Appendix H: Professional Liability Insurance (PLI) Policy*

PUBLIC INTEREST RATIONALE:
Through adopting a proportionate and responsive regulatory approach with the continued policy review based on the guidance of the CRTO Policy Framework.

ISSUE:
During the policy review process, guided by the policy framework, along with the recent By-Law revisions and approval, it has been determined that several policies are repetitive, have been further strengthened in the by-laws, or references other higher-level documents such as by-laws or legislation. For these reasons it is being recommended that the attached policies (in Appendix A, B, C, D, E, F, G and H) be rescinded and archived to increase clarity and avoid potential discrepancies between guiding documents.

BACKGROUND:
Below is a brief rationale on each policy recommended to be rescinded & archived:

- **Appointment of Non-Council Committee Members Policy (Appendix A)**
  This policy references By-Law 2: Council and Committees, section 2. Elections, Appointments & Duties of Council and Committee Members, article 2.13 of the revised CRTO By-Laws. Therefore, the information contained in the policy is repetitive and does not provide new direction to the CRTO beyond what is stated in the By-Law. The Checklist for appointments within the policy will be used as part of the By-Law procedures.

- **Election Process - Executive Committee Policy (Appendix B)**
  The contents of this policy has been merged to By-Law 2: Council and Committees, section 5 Executive Committee, of the revised CRTO By-Law, therefore the information contained in the policy is repetitive and does not provide new direction to the CRTO beyond what is stated in the By-Laws.

- **In-Camera Council Meeting Policy (Appendix C)**
  The majority of the information contained within this policy is stated in section 7 of the *Health Professions Procedural Code* (the *Code*) being Schedule 2 to the *Regulated Health Professions Act, 1991*, (*RHPA)*, further information is in By-Law 2: Council and Committees, Article 4 Council Meetings, and the definition for In Camera under Article 1 Definitions, was added to the revised By-Laws. The policy does not provide new direction to the CRTO beyond what is stated in the By-Laws, therefore the information contained in the policy is repetitive.

- **Responsibilities of Committee Chairs Policy (Appendix D)**
  The contents of this policy has been merged to By-Law 2: Council and Committees, section 7 Committees, article 7.05 of the revised CRTO By-Laws. The policy does not provide new direction to the CRTO beyond what is outlined in the By-Laws, therefore the information contained in the policy is redundant.

- **Code of Conduct for Council Members and Non-Council Members of Committees Policy (Appendix E)**
  The contents of this policy has been added to By-Laws 2: Council and Committees, Schedule A of By-Law 2: Council and Committees Code of Conduct and Conflict of Interest, of the revised CRTO By-Laws. The policy no longer provides new direction to the CRTO beyond what is stated in the By-Laws, therefore the information contained in the policy is repetitive.

- **Appointment of Committee Chairs and Vice-Chairs Policy (Appendix F)**
  The contents of this policy has been merged to By-Law 2: Council and Committees, section 7 Committees, article 7.04 of the revised CRTO By-Law, therefore the information contained in the policy is repetitive and does not provide new direction to the CRTO beyond what is outlined in the By-Laws. The Checklist for appointments within

the policy will be used as part of the By-Law procedures.

- **Change of Name Requests Policy (Appendix G)**
  The authority of this policy is stated in multiple places in the *Regulated Health Professions Act, 1991,* under section 23(2)(1), and By-Law 3: Membership section 3 Duty to Provide Information. This policy is procedure based and guided by the policy framework is better utilized as a fact sheet. Therefore, this policy is no longer needed as it has been redeveloped as a new Name Change Fact Sheet, published on the CRTO website and the name change form has been updated.

- **Professional Liability Insurance (PLI) Policy (Appendix H)**
  This policy was merged with the recently revised By-Laws with an enhanced section on Professional Liability Insurance (By-Law 3: Membership, Section 6 Professional Liability Insurance). Therefore, the information contained in this policy is redundant. The policy does not provide new direction to the CRTO beyond what is outlined in the By-Law. A new Professional Liability Insurance (PLI) Fact Sheet has been created and published on the CRTO website.

RECOMMENDATION:
It is recommended that the CRTO Council approve the policies, as outlined above, to be rescinded and archived as per the attached Motion.

NEXT STEPS:
If the motion is approved the policies will be removed from the CRTO website and archived internally.

Council Motion

AGENDA ITEM # 4.9

Motion Title:	*Consent Agenda Items for Policies Being Rescinded & Archived*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

The CRTO Council approves the items outlined in the policies being rescinded & archived consent agenda (Item 4.9), which include in their entirety:

- Appointment of Non-Council Committee Members Policy (Appendix A)
- Election Process - Executive Committee Policy (Appendix B)
- In-Camera Council Meeting Policy (Appendix C)
- Responsibilities of Committee Chairs Policy (Appendix D)
- Code of Conduct for Council Members and Non-Council Members of Committees Policy (Appendix E)
- Appointment of Committee Chairs and Vice-Chairs Policy (Appendix F)
- Change of Name Requests Policy (Appendix G)
- Professional Liability Insurance (PLI) Policy (Appendix H)

Appendix A: Appointment of Non-Council Committee Members

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Appointment of Non-Council Committee Members**	Number: **CP-Non-Council Committee Members**
Date originally approved: **September 17, 2004**	Date(s) revision approved: **N/A**

POLICY

The By-laws of the College allow for the appointment of Non-Council Committee members when the number of candidates nominated for an electoral district is fewer than the number of members to be elected in the electoral district, or where the seat of a Non-Council Committee member becomes vacant. Current Council policy provides that there be two (2) Non-Council Committee Members in each electoral district.

In determining which members to appoint, consideration will be given to the members' experience, qualifications, abilities and willingness to serve.

Appendix B: Election Process – Executive Committee

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Election Process – Executive Committee**

Number: **CP-Election Executive-142**

Date originally approved:
November 13, 1995

Date(s) revision approved:
November 29, 2012

POLICY

1. In accordance with the *Regulated Health Professions Act, 1991* and College policy, Council will elect an Executive Committee on an annual basis to hold office for a one-year term. The election will take place at the first meeting of Council following the election of Council members, or where there is no election of Council members, corresponding to the date when the election would have been held in other years.
2. The Executive Committee shall be composed of President, Vice President, and three additional Executive Committee members. Three members of the Executive Committee shall be members of Council who are members of the College and two shall be members of Council who are appointed by the Lieutenant Governor in Council.
3. The Registrar will send a notice of election and a call for nominations for the positions of President, Vice-President, and the three (3) additional members of the Executive Committee, to all Council members forty-five (45) days prior to the election or within 5 business days of the close of a general election, whichever is furthest from the date of the Executive Committee election.
4. Candidates for election to the Executive Committee must be nominated by at least two members of Council (a Council member can nominate him/herself).
5. Nominations may be submitted at any time prior to the election. Additional nominations will be accepted from the floor on the day of the election.
6. Notwithstanding item 4, where the Registrar does not receive sufficient interest for any of the five (5) Executive Committee positions by 21 days prior to the election date, a Nominating Committee will be established to seek nominations for those remaining Executive Committee positions.
7. The Nominating Committee will consist of at least two (2) members of Council who are not running for election to the Executive Committee, at least one of whom shall be a public member and at least one of whom shall be a profession member.
8. The election, which will be conducted by the Registrar, will be by secret ballot and will be conducted as the first order of business at the first Council meeting following a general election. For non-election years, this will be conducted at the autumn Council meeting in November/December.
9. Only Council Members present in person at the meeting are entitled to vote (i.e., there is no proxy voting and no voting by telephone, fax or email, or any other electronic means).

Appendix C: In-Camera Council Meeting

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **In-Camera Council Meeting**

Number: **CP-In Camera-170**

Date originally approved:
August 28, 1998

Date(s) revision approved:
N/A

POLICY

In accordance with section 7 of the *Regulated Health Professions Procedural Code*, meetings of Council are open to the public. The code provides for specific occasions when the Council may exclude the public from a meeting or part of a meeting. When the Council excludes the public from a meeting or part of a meeting, it will go *in camera* (conduct the meeting in private).

Council may exclude the public from a meeting or part of a meeting where Council is satisfied that:

- *a) matters involving public security may be disclosed;*
- *b) financial or personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public;*
- *c) a person involved in a criminal proceeding or civil suit or proceeding may be prejudiced;*
- *d) personnel matters or property acquisitions will be discussed;*
- *e) instructions will be given to opinions received from the solicitors from the College; or*
- *f) The Council will deliberate whether to exclude the public from a meeting or whether to make an order to prevent the public disclosure of matters disclosed in the meeting, including banning publication or broadcasting of those matters.*

If Council goes *in camera* the meeting minutes must record the reason for the *in camera* session. The *in camera* portion of the meeting should last only as long as required to discuss the issue or portion of the issue that requires the *in camera* session.

Appendix D: Responsibilities of Committee Chairs

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Responsibilities of Committee Chairs**

Number: **CP-Chairs-175**

Date originally approved:
February 28, 2005

Date(s) revision approved:
N/A

POLICY

With the exception of the Executive Committee, which is chaired by the President, any member of the Committee is eligible to be selected as Chair or Vice-Chair. In accordance with the By-laws, Chairs and Vice Chairs are appointed by the Executive Committee. The operation of the College is dependent upon effective Council and committee meetings. The Chair of each committee is responsible for:

- Presiding over meetings of the committee or Council;
- Calling meetings and setting agendas;
- Selecting panels where required by statute or regulation;
- Ensuring minutes are recorded and reviewing minutes prior to distribution to committee;
- Approving per diem and expense payment for committee members;
- Providing leadership, facilitating discussion and ensuring that committee members have an opportunity to ask questions and express views openly and freely;
- Ensuring the goals and objectives of the committee are met;
- Identifying attendance or other problems with committee members;
- Reporting at each Council meeting the committee activities that have been undertaken since the last report, including an update with respect to the committee's goals and objectives;
- Submitting to Council an Annual Report of the committee's activities at the end of each fiscal year;
- Reviewing the committee budget; and
- Ensuring that the committee operates in accordance with the policies and procedures of the College.

The College provides staff support to each committee to assist the Chair in meeting his/her responsibilities. Each of the above activities will be considered by the Executive Committee when selecting a Chair and vice-Chair for each committee.

Appendix E: Code of Conduct for Council Members and Non-Council Members of Committees

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Code of Conduct for Council Members and Non-Council Members of Committees**

Number: **CP-Code of Conduct-204**

Date originally approved: **September 13, 2002**

Date(s) revision approved: **N/A**

POLICY

In carrying out the duties of a Council or non-Council Committee member, and in serving on committees of the CRTO, it is expected that each Council and non-Council Committee member will use his or her best efforts to:

1. Uphold and promote the mission statement, goals and objectives of the CRTO, and to uphold the public interest.

2. Act honestly, objectively and in good faith in all CRTO matters.

3. Uphold the integrity and reputation of the CRTO in all of his or her actions.

4. Attend meetings of the Council and Committees and perform responsibilities in accordance with the *Regulated Health Professions Act*, *Health Professions Procedural Code*, Regulations, By-Laws, and Policies-Procedures of the CRTO.

5. Respond to communications from staff, Council and Committee members regarding Council and Committee business, in a timely manner.

6. Participate at meetings of the Council and Committees with courtesy, respecting the views expressed and positions taken by others.

7. Maintain decorum in Council and Committee meeting debates including addressing all remarks through the Chair, confining remarks to the pending issue, refraining from attacking a Councillor's motives, refraining from speaking adversely on a prior issue not pending.[1]

8. Refrain from taking any action in the name of the CRTO, except those actions duly authorized by the Council or the Executive Committee.

9. Declare any real, perceived, or potential conflict of interest and remove himself or herself from participating in any discussion involving such conflict, from receiving or viewing any related confidential correspondence, minutes or documents as appropriate concerning such conflict, as soon as the conflict is identified, and to refrain from any vote concerning such conflict.

10. Strictly abide by his or her Confidentiality Agreement with the CRTO, the Confidentiality Policy and Procedure of the CRTO, and the confidentiality provisions of the *Regulated Health Professions Acts* and the *Health Professions Procedural Code.* [2]

[1]Refer to the CRTO By-law, *Rules of Order of Council*.

[2]Refer to CRTO Policy and Procedure-Confidentiality-010, and S.36(1)of the *RHPA*.

Appendix F: Committee Chair and Vice-Chair Appointment

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Appointment of Committee Chairs and Vice Chairs**

Number: **CP-Appt.Ctte Chairs/Vice Chairs-209**

Date originally approved: **June 1, 2018**

Date(s) revision approved: **N/A**

POLICY

With the exception of the Executive Committee, which is chaired by the President, any member of the Committee is eligible to be selected as Chair or Vice-Chair. In accordance with the By-laws, Chairs and Vice Chairs are appointed by the Executive Committee.

Effective functioning of the College's Council and Committees is dependent on the ongoing process of appointing Committee Chairs and Vice Chairs.

1. Chair and Vice Chair positions for all committees shall be appointed by the Executive Committee each year at the conclusion of the last Council meeting of the calendar year or the first meeting after elections take place if it is an election year.
2. All Chair and Vice Chair positions are term limited for a period of 1 year with the opportunity for reappointments
3. Any member of a statutory committee is eligible for appointment to either the Chair or Vice-Chair position of that committee
4. Appointments to Chair and Vice Chair positions shall be made utilizing The Committee Chair Appointment Guidelines (Appendix A)

The College provides staff support to each committee to assist the Chair in meeting his/her responsibilities. Each of the above activities will be considered by the Executive Committee when selecting a Chair and vice-Chair for each committee.

Appendix A – Committee Chair and Vice-Chair Appointment Guidelines

Efficient functioning of the College's statutory committees is dependent upon the leadership, facilitation and meeting management provided by committee Chairs and Vice Chairs.

All Chairs and Vice Chairs should have an understanding and demonstrate a commitment to the public interest mandate of the College. Chairs and Vice Chairs should possess the following attributes:

- Knowledge of the regulatory process
- Effective meeting and management skills
- Excellent judgment
- Strong leadership skills

The following guidelines outline key considerations and information sources that will assist the Executive Committee during the selection and appointment process for these positions.

Committee Chair and Vice Chair Appointment Guidelines

Key Considerations	Information Source	Comments
Is the candidate willing to chair or vice chair a particular committee?	Preference Form	
Has the candidate previously served on this committee? If so, for how long?	Previous Committee Lists	
Does the candidate have a conflict of interest relating to their role of Chair or Vice Chair?	Conflict of interest declaration form	
How has the candidate performed in their role as committee / council member in the past?	Council / Committee member input (i.e. attendance, facilitation skills)	
Does the candidate possess the attributes necessary to Chair or Vice Chair a committee? (see above)	Council / Committee input	

Appendix G: Change of Name Requests

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Change of Name Requests**

Number: **RG-431**

Date originally approved:
March 3, 2017

Date(s) revision approved:
N/A

Background

The name a CRTO Member uses in his/her practice must be the same as the name registered with the CRTO. Under the CRTO By-law (34-01) the CRTO Register of Members must include each Member's name. A Member's name in the register must be supported by documentary evidence submitted with the Member's initial application for registration. In addition, under the By-law, Members must notify the CRTO of any change in the information provided on their application for registration, within 30 days of the effective date of the change (this includes name changes).

This policy outlines the CRTO requirements and processes when considering Members' name change requests. The policy applies to all Members who wish to change their registered name with the CRTO.

POLICY

1. CRTO Member's request for a change of his or her name in the Register must be approved by the Registrar.
2. The Registrar may direct that a Member's name in the Register be changed if the Registrar is satisfied that the Member has validly changed his or her name.
3. To request a change of name, Members must complete the Name Change form and return the form to the CRTO with required supporting documentation; for example:
   - Copy of change of name certificate
   - Copy of Marriage certificate
   - Copy of divorce certificate.

   The documentary evidence must confirm that a person has legally changed his or her name. Documents such as driver licenses or health cards may be submitted in addition to the documents listed above; however on their own they may not be sufficient.
4. After the new name is entered on the CRTO Register, the Member's former name(s) will continue to be publicly available.
5. Using a name other than the Member's name as set out in the Register, in the course of providing or offering to provide respiratory services may be considered an act of professional misconduct.

Appendix H: Professional Liability Insurance

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Professional Liability Insurance Policy**

Number: **RG-INS-404**

Date originally approved:
November 6, 2004

Date(s) revision approved:
July 15, 2007; June 18, 2010, May 25, 2012

POLICY

Purpose

The Regulated Health Professions Act, 1991 (Health Professions Procedural Code) requires all practising regulated health professionals to carry professional liability insurance as follows:

Professional liability insurance

13.1 (1) No member of a College in Ontario shall engage in the practice of the health profession unless he or she is personally insured against professional liability under a professional liability insurance policy or belongs to a specified association that provides the member with personal protection against professional liability.

Insurance requirements

(2) A member mentioned in subsection (1) shall comply with the requirements respecting professional liability insurance or protection against professional liability specified by the College and prescribed in the regulations made under the health profession Act governing the member's health profession or set out in the by-laws.

Professional misconduct

(3) In addition to the grounds set out in subsection 51 (1), a panel of the Discipline Committee shall find that a member has committed an act of professional misconduct if the member fails to comply with subsection (1) or (2).

In addition, subsection 54(2) of Regulation 596/94 (Part VIII - Registration) requires that CRTO Members maintain professional liability insurance in the amount and in the form as required under the by-laws.

This document provides Members with the requirements and rationale for the CRTO's position on liability insurance. In addition, a number of questions are listed for Members' consideration when reviewing individual/employer's policies and determining if coverage is adequate.

Rationale

Liability insurance protects both Respiratory Therapists and the public they serve. Liability insurance enables a patient/client to have adequate financial compensation should harm occur as a result of an error, omission or negligent act, and liability insurance protects the Respiratory Therapist by providing legal and financial support should a patient/client make a claim against them. Members may obtain their liability insurance from any source, including their employer, the professional association, or directly from an insurance company.

Policy – Minimum Liability Coverage

Members engaged in the practice of respiratory therapy: The CRTO by-law requires that Members engaged in the practice of respiratory therapy as outlined in subsection 63 of the Registration Regulation[1] carry minimum liability insurance as follows:

a) The minimum coverage shall be no less than $2,000,000 per occurrence;

b) The aggregate coverage shall be no less than $4,000,000;

c) The insurer must be licensed with the Financial Services Commission of Ontario; and

d) The Member must be personally insured under the insurance policy.

At a minimum, coverage should also include conduct or omissions within the scope of practice of respiratory therapy as defined in section 3 of the *Respiratory Therapy Act,* the *Regulated Health Professions Act* and standards of practice of the profession. The insurance coverage should only have standard exclusion clauses that do not materially detract from comprehensive professional liability coverage, for example, criminal or deliberate acts.

Members registered with Inactive Certificates of Registration or Members who are not engaged in the practice of respiratory therapy: For Members registered with Inactive Certificates of Registration, or for Members who are not currently engaged in the practice of respiratory therapy as outlined in subsection 63 of the Registration Regulation (*see footnote*), the amount of coverage required by the College is set at "zero" providing that the Member has declared on his or her renewal form that he or she:

- Is requesting an exemption from the professional liability insurance requirement on the grounds that he/she is not currently engaged in the practice of respiratory therapy (either inactive or active non-practicing), and
- Has read and understood the professional liability insurance policy of the CRTO and will obtain insurance before practicing.

Examples of available coverage for Respiratory Therapists

- **Employer (hospital, home care company, educational program)**
  If you are covered by your employer's professional liability insurance plan in the amounts and coverage set out in the by-law (see above), then you are not obliged to obtain additional liability insurance coverage, although you may wish to. Members should note that it is not sufficient for the employer's policy just to cover the employer or the facility. The *Health Professions Procedural Code* requires that Members practicing a health profession be "personally insured". This means that you must ensure that your employer's insurance policy covers not just the organization, but you as an individual as well. The policy does not have to list you individually by name but must specify that it covers the "employees" of the organization as "added insureds".

[1] A Member registered with Inactive Certificates of Registration shall not:
(a) engage in providing direct patient care;

(b) use any title or designation listed in the Table to section 67;

(c) supervise the practice of the profession; or

(d) make any claim or representation to having any competence in the profession.

A Member who performs any respiratory therapy services, even on a part time or temporary basis, outside of the employing organization must obtain additional professional liability insurance coverage.

- **Canadian Society of Respiratory Therapists (CSRT)**
  Details are available from the CSRT at www.csrt.com
- **Private insurance providers**
  Consult with your insurance broker.

Individual considerations

The majority of Members will likely have insurance coverage of at least 2 million dollars with their employer. However, Members should determine if these amounts are sufficient according to their specific circumstances (see "Examples of available coverage for Respiratory Therapists – Employer" above). The College recommends that all Respiratory Therapists review their liability insurance coverage from time to time, whether it be an individual plan or one provided by employing agency, for paid or volunteer work. In determining if you have sufficient coverage you may wish to ask yourself the following:

- Does your plan cover reimbursement of legal or criminal defense expenses?
- Will your plan provide for the cost of legal representation in the event you are subpoenaed to appear as a witness?
- What type of coverage does your policy provide e.g., Malpractice, Errors & Omissions, and Legal Expenses?
- What is the liability aggregate limit, 4 million, 10 million?
- Do you have an "occurrence" type of policy (covers claims that occur after the policy has lapsed) or "claims made" policy (only covers you for claims made during the term of the policy)? If you have a "claims made" policy (which is the most common form of liability insurance today) you should ensure that you have enduring coverage (often called "tail insurance") to protect against any claims made after you leave or the particular insurance policy ends.
- Is there a deductible, if so how much? It should not be more than $1,000.00.
- What are the "exclusions" under the policy? Such exclusions should be standard provisions that do not materially detract from comprehensive professional liability coverage (for example, criminal or deliberate acts).
- If you are covered by an employee insurance plan, you should check your coverage and make sure you are an "additional insured" under the policy. You may wish request a letter from the employer confirming coverage. In addition, if you practise outside of your employment you will need to obtain additional insurance to cover those services.
- Finally, you may want to consider if you should purchase additional individual coverage through one of the professional associations.

Council Motion

AGENDA ITEM # 7.0

Motion Title:	*Adjournment*
Date of Meeting:	*April 8, 2022*

It is moved by _____ and seconded by _____ that:

The Council approve to adjourn the *April 8, 2022 Meeting*.