CRTO

Council Meeting Materials

September 24, 2021

College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

AGENDA ITEM # 2.0

10:00 am to 1:00 pm
Zoom Video Conference
https://us02web.zoom.us/j/86491845015

Meeting ID: 864 9184 5015
Passcode: 797564

Find your local number: https://us02web.zoom.us/u/kkSimI5T4

Time	Item	Agenda	Page No.	Speaker / Presenter	Action	Strategic Focus
1000	**1.0**	**Introductions & Land Acknowledgement**		Allison Chadwick		
	2.0	**Approval of Council Agenda**	**2**	Allison Chadwick	Decision	**Governance & Accountability**
	3.0	**Strategic Issues**				
1000	3.1	Executive Committee Elections	**6**	Allison Chadwick	Decision	**Governance & Accountability**
	3.2	Position of Registrar & CEO	**8**	Allison Chadwick	Discussion	**Governance & Accountability**
	3.3	In-camera Session for Position of Registrar & CEO (material to be provided separately)	**NA**	Council	Decision	**Governance & Accountability**
	4.0	**Operational & Administrative Issues**				
1030	4.1	Registrar's Report	**10**	Carole Hamp	Information	**Core Business Practices**
	4.2	Financial Statements	**16**	Carole Hamp	Information	**Core Business Practices**
	4.3	Investment Portfolio	**22**	Carole Hamp	Information	**Core Business Practices**
	4.3.1	Surplus Funds	**26**	Allison Chadwick	Discussion	**Core Business Practices**
	4.4	Membership Statistics	**30**	Lisa Ng	Information	**Core Business Practices**
1100	4.5	RTs Providing Education PPG – Approval for Circulation	**32**	Kelly Arndt	Decision	**Core Business Practices**
	4.6	Documentation PPG – Approval for Circulation	**74**	Kelly Arndt	Decision	**Core Business Practices**
	4.7	Delegation of Controlled Acts PPG – Approval for Circulation	**143**	Kelly Arndt	Decision	**Core Business Practices**
	4.8	Interpretation of Authorized Acts PPG – Approval for Circulation	**200**	Kelly Arndt	Decision	**Core Business Practices**

	5.0	**Consent Agenda Items**	*Consent Agenda: One Decision for Entire Consent Package*			
1130	5.1	Minutes from May 28, 2021	**253**	Allison Chadwick		**Governance & Accountability**
	5.2	Executive Committee Report	**268**	Allison Chadwick		**Governance & Accountability**
	5.3	Registration Committee Report	**269**	Kim Morris		**Governance & Accountability**
	5.4	Quality Assurance Committee Report	**271**	Rhonda Contant		**Governance & Accountability**
	5.5	Patient Relations Committee Report	**272**	Michelle Causton		**Governance & Accountability**
	5.6	Inquiries, Complaints and Reports Committee Report	**273**	Jeff Earnshaw		**Governance & Accountability**
	5.7	Discipline Committee Report	**275**	Lindsay Martinek		**Governance & Accountability**
	5.8	Fitness to Practise Committee Report	**276**	Lindsay Martinek		**Governance & Accountability**
	6.0	**Committee Items Arising**				
1200	**6.1**	**Executive Committee Items:**				
		Terms of Reference & Action Plan		Allison Chadwick		**Governance & Accountability**
	6.2	**Registration Committee Items:**				
		No items for this meeting		Kim Morris		**Governance & Accountability**
	6.3	**Quality Assurance Committee Items:**				
		No items for this meeting		Rhonda Contant		**Governance & Accountability**
	6.4	**Patient Relations Committee Items:**				
		No items for this meeting		Michelle Causton		**Governance & Accountability**
	6.5	**Inquiries, Complaints & Reports Committee Items:**				
		No items for this meeting		Jeff Earnshaw		**Governance & Accountability**
	6.6	**Discipline & Fitness to Practise Committees Items:**				
		No items for this meeting		Lindsay Martinek		**Governance & Accountability**
	7.0	**Legislative and General Policy Issues**				
1230	7.1	Registrar's Reasonable and Probable Grounds Policy - Final Approval	**277**	Jeff Earnshaw	Decision	**Core Business Practices**

7.2	Reporting to Police Policy – Final Approval	**284**	Jeff Earnshaw	Decision	**Core Business Practices**
7.3	Entry-to Practice Exam Policy – Final Approval	**293**	Kim Morris	Decision	**Core Business Practices**
7.4	Handling, Administration and Dispensing of Controlled Substances Practice Policy – Final Approval	**300**	Kelly Arndt	Decision	**Core Business Practices**
7.5	Polices being Rescinded & Archived	**308**	Carole Hamp	Decision	**Core Business Practices**
8.0	**Other Business**				
8.1	2022 Council Dates	**349**	Allison Chadwick	Information	**Governance & Accountability**
9.0	**Next Meeting - Council: December 3, 2021**				
10.0	**Adjournment**				

Open Forum

Tribute to Kevin Taylor, RRT
Registrar & CEO from December 1, 2011 – August 6, 2021.

AGENDA ITEM # 2.0

Motion Title:	*Approval of Council Agenda*
Date of Meeting:	*September 24, 2021*

It is moved by _____ and seconded by _____ that:

The Council approve the Meeting Agenda for September 24, 2021.

AGENDA ITEM # 3.1 **September 24, 2021**

From:	*Executive Committee*
Topic:	*Executive Committee Elections*
Purpose:	*For Discussion*
Strategic Focus:	*Strategic objectives related to Governance and Accountability*
Attachment(s):	

PUBLIC INTEREST RATIONALE:

Holding regulated health professionals accountable to their patient/clients, College and the public.

ISSUE:

1. As of December 2021, there will be two (2) professional member vacancies on the Executive Committee that must be filled.

2. As of December 2021, there needs to be an appointment of two (2) Executive Committee members to the positions of President and Vice-President.

BACKGROUND:

Section 20 of the CRTO By-Laws state:

The Executive Committee shall be elected from the sitting Council members and composed of:

- *three (3) Council members who are Members of the CRTO; and*
- *two (2) public Council members.*

The President and Vice-President of the Council shall be included in the membership of the Executive Committee.

The Council shall, at the first meeting following each regularly scheduled election, or at least annually, from amongst those Council members in attendance, elect a President, Vice-President, and three (3) other Council members to the Executive Committee to hold office for a one (1) year term.

The election of the President, Vice-President and Executive Committee shall be by secret ballot, in accordance with the policies and procedures approved by Council and, where more than two (2) Council members are nominated, the nominee who receives the lowest number of votes on each ballot shall be deleted from nomination unless one nominee receives a majority of the votes cast on the ballot, and this procedure shall be followed until one (1) nominee receives a majority of the votes cast.

The election will be conducted by the Registrar in accordance with CRTO Policies and Procedures. The Registrar will make a call for nominations for the positions of President, Vice-President, and three other Executive Committee members, proceeding in that order.

ANALYSIS:

Our current Executive Committee consists of the following members:

Allison Chadwick, RRT (President) – final term ends Dec. 3, 2021
Rhonda Contant, RRT (Vice-President) – final term ends Dec. 3, 2021
Lindsay Martinek, RRT
Kim Morris (Public Member)
Yvette Wong (Public Member)

RECOMMENDATION:

The Executive Committee recommends appointing Lindsay Martinek to the position of President and Kim Morris to the position of Vice-President at the December Council meeting.

NEXT STEPS:

Two additional members of Council will need to be elected to the Executive Committee at its December meeting.

AGENDA ITEM 3.2 **September 24, 2021**

From:	*Executive Committee*
Topic:	*Registrar & CEO Position*
Purpose:	*For Decision*
Strategic Focus:	*To enable a seamless leadership transition that will allow the CRTO to continue its strategic objectives related to Governance and Accountability.*
Attachment(s):	

PUBLIC INTEREST RATIONALE:
A seamless leadership transition will enable the CRTO to continue fulfilling its mandate of governing the Respiratory Therapy profession in the public interest.

ISSUE:
Due to the tragic loss of our previous Registrar & CEO, Kevin Taylor, the CRTO Executive needs at this time to make a recommendation to Council regarding the appointment of a new Registrar & CEO.

BACKGROUND:
Section 4.01 of the CRTO By-Laws states that *the Registrar may be hired or fired only by a motion passed by a two-thirds (2/3) majority of the sitting Council members in attendance at a Council meeting*.

There are two possible options for Council to choose from, which are:

1. For Council to appoint Carole Hamp RRT, Acting Registrar, to the role of Registrar & CEO.

2. For Council to appoint a Search Committee to conduct an external search for a Registrar & CEO.

CONSIDERATIONS:

- The past 18 months have been a time of upheaval and uncertainty for the CRTO staff due to COVID and the move to working remotely, not to mention Kevin's sudden illness and untimely death. Maintaining the integrity of our high-functioning and close-knit team would provide much-needed consistency. It will also potentially reduce the risk that staff may leave the CRTO, which is more likely to happen whenever there is a significant change in organizational leadership.

- Moving the Acting Registrar into the Registrar role ensures consistency in the organization's strategic direction, such as improved governance and accountability, enhancing engagement and professionalism, and a commitment to anti-discrimination. In addition, it will permit the unbroken continuation of strategic priority initiatives that are already underway, such as the CRTO policy framework and the areas of improvement identified in the CRTO Performance Management Framework (CPMF).

- There are currently six (6) Ontario health-regulatory body Registrars retiring and needing to be replaced between now and the end of this year. Therefore, any external search to replace a Registrar will be highly competitive within a limited pool of qualified applicants.

- As the Ministry of Health continues its discussion regarding "modernizing self-regulation", individuals with the necessary management level experience may be hesitant to enter an employment sector that may be subject to significant structural change in the not-so-distant future.

AGENDA ITEM #4.1

From:	*Carole Hamp, Acting Registrar*
Topic:	*Registrar's Report*
Purpose:	*For Information*

INTERNAL

CURRENT INITIATIVES

Policy Framework & Professional Practice Guidelines

The staff has been working diligently on our large-scale policy revision throughout the summer, and we are nearing completion of our Phase 1 high-priority items. Four policies that have already gone out for public consultation and are being presented the September Council meeting for final approval. In addition, a summary report of the six policies/fact sheets being rescinded and archived will be submitted to Council for their consideration and approval. In the meantime, staff has already begun working on the Phase 2 medium-priority documents. A special shout out to **Sophia** and **Janice** for their work organizing, scheduling, reviewing, and revising. It is a massive project that has been a long time in the making, and we would not have gotten nearly this far without their persistent, ongoing efforts and the collective endeavors of the rest of the team. Thank you also to Sophia and Janice for taking the lead on the roll-out of the new motion template, which we will be using for the first time at our September Council meeting.

Professional Practice Guidelines (PPGs) are part of our overall document framework, but they have their own ongoing cycle for review and revision. Four recently revised PPGs will be presented for approval for circulation to our stakeholders later in the meeting. Thank you, **Kelly**, for all your work on these essential documents. Stay tuned, everyone - there will be more PPGs to come.

QuickBooks Online

The CRTO has officially transitioned from a desktop version of our bookkeeping software to an online format. This move affords us greater data security and allows for multiple users from any device at any time. However, QuickBooks did not make it easy to make the switch, and it required a lot of research, training, and practice runs to get it right. Thanks to Temeka, Amelia, and Stephanie for successfully pulling this off!

ADMINISTRATION

Elections

The call for nominations has begun and will remain open until Friday, September 24th. We have the following seats up for grabs:

District 1 – 1 Council & 2 Non-Council
District 2 - 1 Council & 2 Non-Council
District 5 – 2 Council & 2 Non-Council
District 7 – 1 Council (provincial academic seat)

Professional members - please spread the word to your colleagues and encourage them to fill one of these seats. You can direct anyone interested to the CRTO website for more election information and the steps for filling out a nomination form.

Staffing Changes

By now, you have all learned of the tragic and untimely passing of our Registrar & CEO, **Kevin Taylor**. Kevin led the CRTO for almost 9 ½ years, and words cannot express how deeply he will be missed by the CRTO and the entire RT community. Kevin's involvement with several external organizations, such as HPRO and CNAR, did much to elevate the profile of our profession and garnered a great deal of respect for the CRTO.
We have planned a brief tribute to Kevin to be presented at the end of our September Council meeting.

Amelia Ma, who has been the CRTO's Finance and Office Manager for almost 22 years, has retired. Fortunately for us, she has decided not to go too far away. Amelia is now carrying on some of the work she did previously for the CRTO as an independent contractor. CRTO staff had an in-person staff retreat and semi-retirement party (at Amelia's house) to celebrate the enormous contributions she has made to the CRTO over the years. All the best on this next chapter of your life, Amelia. We know it will be an adventure!

The newest member of our team is **Stephanie Tjandra.** Stephanie started at the CRTO on June 21st and has quickly transitioned into her role as Office Coordinator. Stephanie has taken over the day-to-day financial transactions that Amelia once performed (so it's Stephanie that you send your expense forms to now). In addition to a number of other essential office functions, she also provides administrative support to our Professional Conduct department of Shaf & Sophia Associates. 😊 Stephanie fit into our little team so seamlessly that it is hard to imagine when she was not with us (and she is a Toronto Maple Leafs fan, which makes Shaf very happy).

National Day for Truth and Reconciliation

In recognition of the significant need for broad-based and ongoing education into Indigenous issues, particularly the legacy of the residential school system, CRTO staff will participate in a guided virtual classroom. This session is delivered by Indigenous Corporate Training Inc. and will be held on the morning of **September 29th** (Sept. 30th was all booked up) from 0900 – 12. We have extended an invitation to any Council member interested in joining us.

CRTO's COVID "policy"

Only individuals who have received both doses of a COVID-19 vaccine and are at least two weeks post their 2nd dose will be permitted to enter the CRTO office or attend any of the CRTO's in-person functions. This applies to all CRTO staff, independent contractors, Mentors, Assessors, Members, Council and Committee members, and anyone else seeking access to the CRTO. Any person who is not fully vaccinated will be required to interact with the CRTO via email, telephone, or videoconferencing.

Public Appointments Office

We have been blessed with two new public appointments to our Council. **Derek Clark** and **Allison Peddle** have now joined our team and are both attending our September Council meeting. Welcome, Derek & Allison!

EXTERNAL

Accreditation of RT Educational Programs

Accreditation Canada and their subsidiary, the Health Standards Organization (HSO), administers the accreditation of RT educational programs through EQual. CRTO staff (Carole and Kelly) participate as part of the Ontario programs' accreditation teams – the next ones being for the Michener Institute for Education at UHN and Canadore and Conestoga College.

College Performance Management Framework (CPMF)

The CRTO submitted its report to the Ministry on March 31st. We have added the CPMF and its associated improvements to our strategic directions for the year ahead. Those strategic priorities are:

- Improved Governance and Accountability
- Responding to the Needs of the Health Care System
- Enhancing Engagement & Professionalism
- Commitment to Anti-Discrimination

At this point, all the Colleges are awaiting the Ministry's final approval. However, we are already moving forward with several initiatives targeted at addressing the above-mentioned areas of improvement, such as:

- Website redesign aimed at increasing accessibility and ease of finding material
- Ongoing education for Council and Committee members, as well as CRTO staff (e.g., Financial Literacy training and online modules, Indigenous awareness virtual classroom)
- Posting agendas for all Committee meetings on the CRTO website (starting with the Executive Committee agenda)
- Amending the CRTO investment policy to include a section on financial reserves (draft to be considered by Council at their September meeting)

HPRO

Compensation Survey

The CRTO is participating in an HPRO-led survey designed to establish an up-to-date compensation framework for Registrar's and College staff (e.g., salaries, vacation, benefits, etc.). The company implementing the survey is the Mungall Consulting Group, and the resulting data is expected to be available this fall. The information received is essential in ensuring that the CRTO can continue to recruit and retain high-caliber employees.

Modernizing Privacy in Ontario

In late June of this year, Richard Steinecke released a paper entitled *Analysis of White Paper on Modernizing Privacy in Ontario: For the Health Profession Regulators of Ontario.*
Richard's article responds to recently proposed changes to the Personal Health Information Protection Act (PHIPA) – primarily expanding privacy requirements to include "non-commercial organizations". This has raised concerns that health regulatory bodies will become subject to additional privacy requirements that may impede their existing regulatory processes. For example, having a third party (other than a court) determine whether it was fair and appropriate for a College to collect the information (e.g., during the course of an investigation) would be disruptive to a College's regulatory activities. In addition, if the revisions apply to Colleges, the Information, and Privacy Commissioner of Ontario (IPC), would have oversight of the Colleges' information practices. This would have a significant impact on the operation of Colleges and provide practitioners, complainants, and witnesses with another route to challenge College decisions.
HPRO has submitted a response to the white paper that outlines these and other concerns.

Anti – Black, Indigenous, and People of Color (BIPOC) Racism Project

Facilitated virtual focus group sessions were held in July for the Registrars and staff of the health regulatory Colleges. This project aims to ensure all Colleges have the necessary tools to recognize and address systemic racism within their organizational processes and

members' interaction with the general public. Internally, the CRTO has begun this process by reviewing and revising its Employee Handbook to ensure it reflects the College's values regarding equity, inclusivity, and diversity. We will also consider how best to communicate the CRTO's expectations that its Members provide patient care free from any form of discrimination.

Policy on Information Sharing

The CRTO is participating in a recently created working group looking at how and when Colleges share information with external parties (e.g., the police). At its first meeting, the group established a list of potential external parties and stakeholders with whom any information sharing could potentially be impacted.

Labour Mobility

We have been working with our Government Relations firm (Grosso McCarthy) with the goal of making one more attempt to achieve a legitimate objective under chapter 7 of the Canadian Free Trade Agreement. The CRTO has been advocating since 2009 to address the risk of harm posed by U.S-trained RTs who register in Alberta and then apply to Ontario under the Labour Mobility provision. Up to this point, there has been little interest on behalf of the Ontario government to exempt the CRTO from this provision, despite well-established competency gaps. However, some current circumstances may make it a more conducive environment to repeat our request.

Office of the Fairness Commissioner (OFC) - Risk-informed Compliance Framework

On April 1, 2021, the OFC launched its new Risk-informed Compliance Framework. The first year of the framework was intended to serve as a transitional period during which the OFC reviewed the historical performance of each regulator and placed them in a provisional compliance category. The five historical performance indicators they considered during this transitional period are:

1. The nature and extent of material compliance recommendations that the OFC has issued to the regulator in the last compliance cycle.

2. The extent to which the regulator has completed these recommendations and avoided new issues.

3. The regulator's observed motivation to work with the OFC on defined compliance objectives.

4. The content of decisions issued by the courts or tribunals that discuss the regulator's registration practices.

5. The degree to which the regulator's registration processes exhibit the attributes of transparency, objectivity, impartiality, and fairness, as demonstrated, for example, by the number of OFC.

The CRTO was informed on August 26th that the CRTO was assigned a "**full compliance**" provisional rating! This means that we have successfully implemented each of the compliance recommendations that the OFC has issued, additional recommendations were not identified, and all other criteria have been met.

In the Fall of this year, they will be contacting all regulators again to gather information about forward-looking risk factors pertaining to the conduct of registration processes. This information will allow the OFC to allocate a risk category to each organization.

AGENDA ITEM #4.2

From:	*Carole Hamp, Acting Registrar*
Topic:	*Financial Statements*
Purpose:	*For Information*

Attached is the CRTO Financial Statements as of August 31, 2021.

College of Respiratory Therapists of Ontario
Balance Sheet Comparison
As of August 31, 2021

	Total	
	As of Aug. 31, 2021	As of Aug. 31, 2020
Assets		
Current Assets		
Cash and Cash Equivalent		
1050 Petty Cash	300.00	300.00
1100 Bank-CIBC	1,003,962.51	1,084,460.71
Total Cash and Cash Equivalent	**$ 1,004,262.51**	**$ 1,084,760.71**
Accounts Receivable (A/R)		
1200 Accounts Receivable	11,417.52	25,492.52
Total Accounts Receivable (A/R)	**$ 11,417.52**	**$ 25,492.52**
1116 CIBC GIC	501,476.44	493,406.57
1118 Investment - Wood Gundy	1,026,199.05	752,900.43
1119 Investment - Wood Gundy Cash	0.15	7,145.90
1190 Prepaids	95,988.23	54,270.76
Total Current Assets	**$ 2,639,343.90**	**$ 2,417,976.89**
Non-current Assets		
Property, plant and equipment		
1310 Furniture & Equipment	70,807.85	70,655.98
1320 Computer	36,424.89	31,457.41
1330 Database	459,127.64	459,127.64
1332 Mobile App	84,433.40	92,230.40
1340 Accum.Dep'n-Furniture&Equipment	-68,094.83	-67,493.22
1350 Accum. Dep'n - Computers	-31,814.19	-30,044.79
1360 Accum. Dep'n - Database	-372,773.61	-331,619.95
1361 Accum.Dep'n-Mobile App	-84,433.40	-84,433.40
1370 Lease improvements	153,875.93	153,875.93
1380 Accum. Dep'n - Leasehold Improv	-153,875.93	-153,875.93
1500 Equipment under captial lease	60,850.00	60,850.00
1520 Accumulated depre'n-capital lea	-6,085.00	0.00
2700 Obilgation under captial lease	-47,505.72	-60,850.00
Total Property, plant and equipment	**$ 100,937.03**	**$ 139,880.07**
Total Non Current Assets	**$ 100,937.03**	**$ 139,880.07**
Total Assets	**$ 2,740,280.93**	**$ 2,557,856.96**
Liabilities and Equity		
Liabilities		

Current Liabilities				
2210 Accrued Liability		101,245.98		69,936.19
Total Current Liabilities	**$**	**101,245.98**	**$**	**69,936.19**
Total Liabilities	**$**	**101,245.98**	**$**	**69,936.19**
Equity				
3110 Gen. Contingency Reserve Fund		500,000.00		500,000.00
3150 Reserve for Funding of Therapy		80,000.00		80,000.00
3651 Reserve for COVID-19 Fund		250,000.00		
3652 Reserve, Investigations&Hearing		150,000.00		150,000.00
3653 Special Projects Reserve Fund		300,000.00		300,000.00
Retained Earnings		332,669.06		1,457,920.77
Profit for the year		1,276,365.89		
Total Equity	**$**	**2,639,034.95**	**$**	**2,487,920.77**
Total Liabilities and Equity	**$**	**2,740,280.93**	**$**	**2,557,856.96**

College of Respiratory Therapists of Ontario
Income Statement - Budget vs. Actuals
March 1, 2021 - August 31, 2021

	Mar.1-Aug.31,2021	Budget	+/- Budget	% of Budget	Mar.1-Aug.31,2020
Income					
4100 Registration Application Fees	5,400.00	15,000.00	-9,600.00	36.00%	600.00
4200 Registration & Renewal Fees	2,352,700.00	2,340,000.00	12,700.00	100.54%	2,262,705.00
4210 Competency Assessment-Stage1&2	-803.00	4,000.00	-4,803.00	-20.08%	500.00
4211 Competency Assessment (CSA)	4,250.00	8,500.00	-4,250.00	50.00%	11,000.00
4300 Penalty Fees	4,812.50	5,000.00	-187.50	96.25%	5,812.50
4400 Misc. Revenue	340.00	45.00	295.00	755.56%	45.00
4600 Investment Income	12,305.27	11,351.00	954.27	108.41%	6,028.97
Total Income	**$ 2,379,004.77**	**$ 2,383,896.00**	**-$ 4,891.23**	**99.79%**	**$ 2,286,691.47**
Expenses					
5000 Admin./Operational Expenses					
5010 Staff Salaries	619,345.07	1,088,650.60	-469,305.53	56.89%	462,725.17
5020 Staff Benefits	37,867.48	68,033.30	-30,165.82	55.66%	29,073.08
5030 CPP&EI-Employer Contribution	28,548.44	40,555.40	-12,006.96	70.39%	24,436.49
5031 Staff RSP	15,395.76	32,455.14	-17,059.38	47.44%	12,281.87
5035 Employer Health Tax (EHT)	0.00	1,728.69	-1,728.69	0.00%	0.00
5040 Staff Training & Development	844.74	5,000.00	-4,155.26	16.89%	0.00
5041 Staff Personal Education	499.00	8,000.00	-7,501.00	6.24%	359.46
5045 Staff-Travel & Expense-Misc.	1,963.98	5,000.00	-3,036.02	39.28%	46.14
5050 Equipment (Non-Capitalized)	1,250.00	2,500.00	-1,250.00	50.00%	0.00
5060 Rent & Occupancy	101,982.95	215,585.50	-113,602.55	47.31%	104,050.19
5070 Equipment Leases & Maintenance	6,859.24	13,876.00	-7,016.76	49.43%	10,101.74
5090 Insurance	3,473.28	6,111.60	-2,638.32	56.83%	3,303.72
5110 Accounting & Audit	-10,452.50	10,000.00	-20,452.50	-104.53%	-10,000.00
5120 Legal - General	11,221.34	25,000.00	-13,778.66	44.89%	6,622.65
5121 Legal - Investigation&Hearing	5,640.55	20,000.00	-14,359.45	28.20%	3,956.50
5130 Expenses-Investigations&Hearing	3,274.25	25,000.00	-21,725.75	13.10%	3,246.83
5131 Investigation Services	73,153.13	75,000.00	-1,846.87	97.54%	36,246.34
5140 Consulting - General	20,876.70	15,000.00	5,876.70	139.18%	5,073.70
5210 Telephone/Fax/Internet	13,181.46	13,432.82	-251.36	98.13%	7,874.69
5220 Computer Software	7,172.26	20,000.00	-12,827.74	35.86%	18,883.81
5221 Computer Hardware	6,504.25	4,000.00	2,504.25	162.61%	0.00
5223 Website Hosting	2,124.03	4,154.00	-2,029.97	51.13%	254.25
5224 Website Development	12,300.05	12,000.00	300.05	102.50%	2,034.00
5230 Postage/Courier - General	1,725.14	7,000.00	-5,274.86	24.64%	1,028.64
5240 Printing - General	2,067.52	10,000.00	-7,932.48	20.68%	754.66
5250 Translation - General	10,930.12	20,000.00	-9,069.88	54.65%	2,113.10
5310 Office Supplies	3,489.44	7,500.00	-4,010.56	46.53%	5,917.43
5320 Office Maintenance/Upkeep	2,055.86	4,000.00	-1,944.14	51.40%	1,896.97

5321 Office Meeting Expenses	1,162.85	1,000.00	162.85	116.29%	232.08
5330 Bank Account Charges	826.12	1,281.97	-455.85	64.44%	664.23
5331 Paypal Charges	696.84	1,347.02	-650.18	51.73%	749.20
5340 Credit Card Merchant Fees	9,031.30	74,371.05	-65,339.75	12.14%	5,408.44
5350 Conference Registration Fees	111.87	6,500.00	-6,388.13	1.72%	4,802.50
5380 Membership/Subscriptions	13,810.65	21,000.00	-7,189.35	65.77%	13,661.36
5381 Alliance Expenses	0.00	1,000.00	-1,000.00	0.00%	47.58
5385 Accreditation Services	3,089.22	18,000.00	-14,910.78	17.16%	3,089.22
5500 QA Portfolio Reviewers	15,939.48	20,000.00	-4,060.52	79.70%	15,731.51
5516 QA PORTfolio Annual Fee	0.00	39,550.00	-39,550.00	0.00%	0.00
5518 QA PORTfolio Dev't	0.00	10,000.00	-10,000.00	0.00%	0.00
5521 Competency Assessment-Phase1&2	1,099.30	4,000.00	-2,900.70	27.48%	300.00
5522 Competency Assessment-CSA	15,527.92	17,000.00	-1,472.08	91.34%	1,374.85
5523 Comp. Assessment-Train/Dev't	0.00	3,000.00	-3,000.00	0.00%	11,300.00
5545 Outreach Activities-Travel/Exp.	1,124.35	2,000.00	-875.65	56.22%	1,124.35
5546 Communications - General	0.00	3,000.00	-3,000.00	0.00%	0.00
5547 Communications - Social Media	0.00	1,500.00	-1,500.00	0.00%	0.00
5610 Education Day Expenses	186.45	10,000.00	-9,813.55	1.86%	0.00
5620 Data Base Development	0.00	50,000.00	-49,813.55	0.37%	5,445.19
5623 Database Annual Software Fee	0.00	0.00	0.00	0.00%	46,294.97
5624 Database Hosting	5,123.60	9,500.00	-4,376.40	53.93%	4,176.38
5700 Unrealized Gain/Loss (investmt)	-2,164.00	0.00	-2,164.00	0.00%	-926.00
5932 Student Council Rep.	0.00	0.00	0.00	0.00%	1,363.64
Total 5000 Admin./Operational Expenses	**$ 1,048,859.49**	**$ 2,053,633.09**	**-$ 1,004,773.60**	**51.07%**	**847,120.93**
6000 Council					
6010 Council - Meeting Per Diems	2,400.00	0.00			1,750.00
6020 Council - Prep Time Per Diems	1,800.00	0.00			1,600.00
6030 Council - Travel Time Per Diems	0.00	0.00			366.21
6040 Council - Meals	0.00	0.00			1,216.40
6050 Council - Accommodation	0.00	0.00			442.08
6060 Council - Travel Expense	0.00	0.00			850.07
Total 6000 Council	**$ 4,200.00**	**$ 12,000.00**	**$ 7,800.00**	**35.00%**	**$ 6,224.76**
6100 Executive					
6110 Executive - Meeting Per Diems	0.00	0.00			500.00
6120 Executive - Prep Time Per Diems	400.00	0.00			100.00
6170 Executive Telephone	200.00	0.00			68.72
Total 6100 Executive	**$ 600.00**	**$ 4,200.00**	**-$ 3,600.00**	**14.29%**	**$ 668.72**
6200 Registration					
6210 Registration-Meeting Per Diems	537.00	0.00			425.00
6220 Registration-PrepTimePerDiems	1,225.00	0.00			625.00
6270 Registration - Telephone	0.00	0.00			85.94
6297 Registration- Educ/Training	3,654.42	0.00			
Total 6200 Registration	**$ 5,416.42**	**$ 11,875.00**	**-$ 6,458.58**	**45.61%**	**$ 1,135.94**

6300 Pat.Rel.					
6310 Pat.Rel.-Meeting Per Diems	450.00	0.00			
6320 Pat.Rel.-Prep Time Per Diems	450.00	0.00			
Total 6300 Pat.Rel.	**$ 900.00**	**$ 9,000.00**	**-$ 8,100.00**	**10.00%**	**$ 0.00**
6400 QA					
6410 QA - Meeting Per Diems	725.00	0.00			
6420 QA - Prep Time Per Diems	500.00	0.00			
Total 6400 QA	**$ 1,225.00**	**$ 12,000.00**	**-$ 10,775.00**	**10.21%**	**$ 0.00**
6500 ICRC					
6510 ICRC-Mtg Per Diems	2,600.00	0.00			1,712.50
6520 ICRC-Prep Time	2,050.00	0.00			2,825.00
6530 ICRC-Travel Time	0.00	0.00			131.38
6540 ICRC-Meals	0.00	0.00			512.06
6550 ICRCAccom.	0.00	0.00			928.32
6520 ICRC-Travel Exp.	0.00	0.00			282.46
6597 ICRC-Educ/Training	616.97	0.00			
Total 6500 ICRC	**$ 5,266.97**	**$ 16,000.00**	**-$ 10,733.03**	**32.92%**	**$ 6,391.72**
6600 Discipline					
6697 Discipline-Education/Training	915.00	0.00			
Total 6600 Discipline	**$ 915.00**	**$ 3,400.00**	**-$ 2,485.00**	**26.91%**	**$ 0.00**
6700 Fitness		1,700.00	-1,700.00	0.00%	
Total Expenses	**$ 1,067,382.88**	**$ 2,123,808.09**	**-$ 1,056,425.21**	**50.26%**	**$ 861,542.07**
Net Operating Income	**$ 1,311,621.89**	**$ 260,087.91**	**$ 1,051,533.98**	**504.30%**	**$ 1,425,149.40**
8000 Special Projects					
5555 Scope of Practice Monitoring	35,256.00	85,000.00	-49,744.00	41.48%	42,307.20
Total 8000 Special Projects	**$ 35,256.00**	**$ 85,000.00**	**-$ 49,744.00**	**41.48%**	**$ 42,307.20**

AGENDA ITEM #4.3

From:	*Carole Hamp, Acting Registrar*
Topic:	*Investment Portfolio*
Purpose:	*For Information*

Attached is the CRTO Investment Portfolio Distribution ending August 31, 2021.

CRTO Investment Portfolio - Distribution
August 31, 2021

Investment Category	Term Limitation	Fund Limitation	Minimum Rating	Additional Fund Limitations		Current Investments	Book Value ($)	Portfolio %
Cash		Unlimited					**1,479,167**	**67%**
						Regular Chequing Account	1,003,963	45%
						REN HIGH INT SAVINGS	**372,887**	17%
						(including $250,000 COVID surplus amount)		
						CIBC HIGH INT SAVINGS	102,318	5%
Federal Government:							**0**	**0%**
Bonds	365 days to 3 years	50%					0	0%
Bonds	3 to 5 years	20%		Total investments 3 to 5 years not to exceed 20% of Fund			0	0%
Provincial Government:				a. Total provincials not to exceed 50% of Fund b. Investment in any one province not to exceed 25%			**0**	**0%**
Securities/Notes	365 days	40%	AA				0	0%
Bonds	365 days to 3 years	40%	AA				0	0%
Bonds	3 to 5 years	20%	AA	Total investments 3 to 5 years not to exceed 20% of Fund			0	0%
Schedule "A" Banks:							**742,638**	**33%**
GICs	365 days to 3 years	75%		Total investments in any one bank not to exceed 35% of total portfolio		GIC Holdings		
						Effort Trust Company GIC 0.8%3May22 (1 Yr)	100,000	5%
						HOME TRUST COMPANY 1.18% 28Jn22 (2 Yr)	63,400	3%
						VANCITY CREDIT UNION .80% 6Jn22 (1 Yr)	51,000	2%
						CIBC GIC .45% 26Ap22 (1 Yr)	498,343	22%
						HAVENTREE BANK GIC .97% 27Oct22 (2 Yr)	47,314	
						HOME TRUST COMPANY .9% 27Oct22 (2 Yr)	36,600	2%
						INDUSTRIAL & COMMERCIAL BANK OF CHINA .85% 27Oct22 (2 Yr)	45,981	2%
						CDN WESTERN BANK 1.25% 9Dec23 (3 Yr)	100,000	5%
						EQUITABLE BANK 1.25% 9Dec.23 (3 Yr)	100,000	5%
Banker's Acceptance	365 days to 3 years	50%					**0**	**0%**
Canadian Corporations:								
Commercial Paper	365 days	10%	R-I Mid	Limit any single holding to 10% of Fund			0	0%
						Total	**2,221,805**	**100%**

SECURITY INCOME ANALYSIS (CAD)

As of August 31, 2021

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO ATTN KEVIN M TAYLOR (420075002C)

Margin
Your Investment Advisor: J B MOORE

Quantity	Description	Opening Date	Book Value	Market Value	Unrealized G/L **	Accum. Int./Div.	Total Return	Total Return (%)
CASH & CASH EQUIVALENTS								
Cash								
748	ACCOUNT BALANCE CAD		748.12	748.12		172.57		
High Interest Savings Account								
102,465.790	CIBC HIGH INT SAVINGS ACC (CTC) CL A (5002)	04/19/2016	102,465.79	102,465.79	0.00	6,466.34	6,466.34	6.31
372,887.400	RENAISSANCE HIGH INT SAVINGS ACCOUNT (5000)	11/24/2009	372,887.40	372,887.40	0.00	5,347.72	5,347.72	1.43
Total High Interest Savings Account			**$ 475,353.19**	**$ 475,353.19**	**$ 0.00**	**$ 11,814.06**	**$ 11,814.06**	**2.49 %**
Others								
100,000	EFFORT TRST CO GIC A 0.8% 3MY22	04/30/2021	100,000.00	100,000.00	0.00		263.01	0.26
51,000	VANCITY SAVINGS CREDIT UNION GIC A 0.8% 8JN22	06/07/2021	51,000.00	51,000.00	0.00		93.90	0.18
63,400	HOME TRST CO GIC A 1.18% 30JN22	06/29/2020	63,400.00	63,400.00	0.00	748.12	875.20	1.38
Total Others			**$ 214,400.00**	**$ 214,400.00**	**$ 0.00**	**$ 748.12**	**$ 1,232.11**	**0.57 %**
Total Cash & Cash Equivalents			**$ 690,501.31**	**$ 690,501.31**	**$ 0.00**	**$ 12,734.75**	**$ 13,046.16**	**1.89 %**
SHORT-TERM FIXED INCOME								
Guaranteed Investment Certificate								
47,314	HAVENTREE BNK GIC CA 31OC22	10/28/2020	47,314.00	47,698.47	384.47		384.47	0.81
36,600	HOME TRST CO GIC CA 31OC22	10/28/2020	36,600.00	36,875.96	275.96		275.96	0.75
45,981	IND & COMM BK CHINA (CDA) GIC CA 31OC22	10/28/2020	45,981.00	46,308.43	327.43		327.43	0.71
100,000	CDN WESTERN BNK GIC CA 9DC23	12/08/2020	100,000.00	100,906.00	906.00		906.00	0.91
100,000	EQTBL BNK GIC CA 11DC23	12/08/2020	100,000.00	100,906.00	906.00		906.00	0.91
Total Short-Term Fixed Income			**$ 329,895.00**	**$ 332,694.87**	**$ 2,799.87**		**$ 2,799.87**	**0.85 %**
Total			**$ 1,020,396.31**	**$ 1,023,196.18**	**$ 2,799.87**	**$ 12,734.75**	**$ 15,846.03**	**1.55 %**

SECURITY INCOME ANALYSIS (CAD)

As of August 31, 2021

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO ATTN KEVIN M TAYLOR (420075002C)

Margin

Your Investment Advisor: J B MOORE

Accrued Interest:	**$ 484**
Declared and Unpaid Dividends:	
Total Portfolio Value:	**$ 1,023,680**

**** Where applicable, Unrealized G/L includes accumulated interest. Accumulated interest is included in the ''Unit Cost'' / ''Invested Cost'' and in the ''Book Value'' / ''Invested Capital'' columns.**

AGENDA ITEM # 4.3.1 **September 24, 2021**

From:	*Executive Committee*
Topic:	*Surplus Funds*
Purpose:	*For Discussion*
Strategic Focus:	*Core Business Practices*
Attachment(s):	

PUBLIC INTEREST RATIONALE:

Ensuring that the CRTO can continue regulating the profession of Respiratory Therapy in the public interest.

ISSUE:

Due to the COVID-19 pandemic, certain expenses usually incurred by the CRTO have been reduced (i.e., costs for in-person meetings). Therefore, the CRTO has a surplus of funds from the 2020 – 2021 fiscal year. This surplus exceeds the required amount to cover operating costs and meet our legislated reserve funds obligations.

BACKGROUND:

The CRTO is a Non-Profit Organization (NPO). While regular businesses pay surpluses to their shareholders, such as by offering dividends, NPOs are not permitted to provide financial benefits to their members. NPOs are generally expected to use their funds to enhance their ability to provide their designated service.

NPOs are allowed to earn income in excess of their expenditures, as long as they do so in line with the organization's official purpose. The Canada Revenue Agency (CRA) has no hard and fast rule regarding the amount of surplus considered reasonable and makes its determination on a case-by-case basis. Factors they consider are the stability of the organization's income sources and future anticipated expenditures.

For the CRTO, an additional consideration is our anticipated expenditures due to the significantly rising cost of professional conduct investigations. The CRTO, like most other Colleges, has been increasingly busy on the professional conduct side and has one substantial case currently underway and another possibility heading to discipline. These types of conduct matters require the use of external investigation firms, which are progressively more in-demand and costly. And so, although the CRTO does retain a reserve fund for investigations and hearings ($150,000), a discipline hearing – particularly one that is contested – can quickly deplete that account.

ANALYSIS:

Outlined here are two (2) options regarding the CRTO's current and anticipated financial surplus:

1. **Retain the amount in a Fee Stabilization Fund reserve**

   In the past, the CRTO has reserved money in a Fee Stabilization Fund ($150,000). By 2016, that amount was no longer sufficient to meet the needs of our rising operating costs. At that point, the fund was closed, and Council made the decision to increase membership fees. There have also been additional fee increases applied in subsequent years. Therefore, one possible option is to re-establish the Fee Stabilization Fund to hopefully avoid any fee increases for at least the next few years.

   Pros:

   - This would prevent us from having to raise fees, at least as long as the pandemic is impacting our Members.

   - It would ensure that additional funds are available to the CRTO in the event of an unforeseen emergency

   Cons:

   - Given the protracted nature of the current pandemic, it is conceivable that the CRTO will have an additional surplus this fiscal year. Therefore, the distribution of the surplus will need to be evaluated on an ongoing basis.

2. **Reducing the annual membership fees**

We could reduce our membership fee by a certain amount, either as a one-time event or for the next few years.

Pros:

- This would reduce our overall income and require us to allocate some or all of the surplus into our operating budget.

Cons:

- This would likely be confusing to our members when we eventually have to increase fees again in the future.

3. **Return a one-time amount to the Members**

It is possible to redistribute surplus funds back to our membership. However, to avoid jeopardizing our NPO status with CRA, certain factors need to be considered. Advice received from our Auditor regarding this matter is as follows:

1) The CRTO must first prove and have financial records to support the refund is to return the overcharged portion of the membership fees, not a refund of the college's income;

2) Secondly, the refund should be made proportionately to all the members (i.e., you need to come up with a total refundable fee and divide that by the total number of members instead of deciding a set amount of $100 or $200 per member); and

3) Lastly, the refund should be treated as a reduction of membership dues when the members file their personal tax returns.

Pros:

- It would allow us to redistribute our surplus.

Cons:

- The amount is likely to be relatively small and thus may not be well received by the Members.

- It will require a significant amount of administrative support from CRTO to calculate and distribute the funds, as not all Members pay the same amount (i.e., or at the same time in the fiscal year.

AGENDA ITEM #4.4

From:	*Lisa Ng, Registration Manager*
Topic:	*Membership Statistics*
Purpose:	*For Information*

CRTO MEMBERSHIP STATISTICS

for Council September 24, 2021

Report generated September 7, 2021

Membership	Sept 2021	At last Council May 2021	1 year ago Sept 2020	5 years ago Sept 2016
Total members	**3871**	**3815**	**3783**	**3432**
General Class	3560	3419	3392	3171
Graduate Class	27	104	144	12
Limited Class	4	5	5	6
Inactive Class	280	287	242	243
Status Changes	**Mar 2020 - Sept 2021**	**Mar 2020 - May 2021**	**Mar 2020 - Sept 2020**	**Mar 2016 - Sept 2016**
Resigned	**165**	**154**	**54**	**34**
Retired	82	71	18	13
Moved out of Ontario	44	35	17	11
Working in other profession	23	24	11	5
Personal/Other Reasons	16	24	8	5
Undertaking	0	0	0	0
Suspended	**20**	**20**	**15**	**19**
due to non-payment of fees	19	19	14	19
due to disciplinary decisions	1	1	1	0
other reasons	0	0	0	0
Revoked	**16**	**16**	**3**	**19**
due to non-payment of fees	13	13	1	18
due to disciplinary decisions	0	0	0	0
due to expiration of Grad Certs	3	3	2	1
Reinstated	**39**	**33**	**29**	**10**
from resigned	22	19	26	4
from suspended	2	2	1	2
from revoked	15	12	2	4
New Applications	**Mar 2020 - Sept 2021**	**Mar 2020 - May 2021**	**Mar 2020 - May 2021**	**Mar 2016 - Sept 2016**
Applications Received	**406**	**362**	**166**	**139**
Ontario Graduates	350	313	147	125
Other Canadian Grads	33	30	10	7
USA Graduates	7	5	5	4
International Graduates	16	14	4	3

AGENDA ITEM # 4.5 **September 24, 2021**

From:	*Kelly Arndt RRT, Quality Practice Coordinator*
Topic:	*Draft Revised Respiratory Therapists Providing Education Professional Practice Guideline (PPG)*
Purpose:	*For Decision*
Strategic Focus:	*Protecting patient safety by ensuring that Respiratory Therapists understand their professional responsibilities and obligations in providing education*
Attachment(s):	Appendix A - Current RT Providing Education PPG Appendix B – Revised RT Providing Education PPG

PUBLIC INTEREST RATIONALE:

This PPG enables Respiratory Therapists in Ontario to understand the expectations and professional responsibilities set out by the CRTO regarding RTs as Educators.

ISSUE:

Previously revised in March 2015, the RT as Educators PPG has been reviewed and updated. Although it is mentioned in the CRTO's Standards of Practice 13, Professional Responsibilities, this PPG sets out further direction for RTs in all aspects of educating, including the role of delegation, supervision, and documentation.

BACKGROUND:

Respiratory Therapists possess a unique body of knowledge, which when shared with others, promotes the best possible outcome for patients, colleagues, students, and the public. 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 is unchanged. The content has been updated to include the expectations of RT's in educating Respiratory Therapy students, elaboration on supervision and documentation, along with the introduction of the importance of positive role modelling.

RECOMMENDATION:

It is recommended that the CRTO Council review and approve the revised Respiratory Therapists Providing Education PPG for circulation for feedback from members and stakeholders as per the attached motion.

NEXT STEPS:

If the motion is approved, the PPG with be circulated for public consultation and review. A final draft will be presented to Council at the December 2021 meeting.

AGENDA ITEM # 4.5

Motion Title:	*Draft Revised Respiratory Therapists Providing Education Professional Practice Guideline*
Date of Meeting:	*September 24, 2021*

It is moved by _____ and seconded by _____ that:

Council approves the *Draft Revised RTs Providing Education Professional Practice Guideline* for circulation and feedback. (A copy is attached as Appendix B to this motion within the materials of this meeting).

Current Respiratory Therapists Providing Education Professional Practice Guideline

College of Respiratory Therapists of Ontario

Professional Practice Guideline

Respiratory Therapists Providing Education

College of Respiratory Therapists of Ontario (CRTO) publications contain practice parameters and standards which should be considered by all Ontario Respiratory Therapists (RTs) 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.

It is important to note that employers may have policies related to an RT's authority to perform certain procedures; including controlled acts, authorized acts and acts that fall within the public domain. 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.

March 2015

The words and phrases in **bold** lettering can be cross referenced in the Glossary at the end of the document.

Table of Contents

INTRODUCTION

Respiratory Therapists (RTs) possess a unique body of knowledge and therefore, have the opportunity to share and enable other to develop expertise and confidence. In one way or another, all RTs provide education to those around them. However, it is important to differentiate between RTs who provide education and RT educators.

RTs Who Provide Education

The *Therapeutic & Professional Relationships* standard in the CRTO *Standards of Practice* outlines the expectation for Respiratory Therapists (RTs) who are **Members** of the College of Respiratory Therapists of Ontario (CRTO) to "*share appropriate knowledge and expertise with colleagues, peers, patients/clients, students and others*". In general, this means that RTs in all practice settings have some role in providing education, with a professional obligation to share knowledge and expertise with others.

The CRTO Standards of Practice also articulates the expectation that RTs "*promote respiratory health and patient/client independence through education, coaching and counseling*". RTs accomplish this by:

- demonstrating best practices to students;
- providing presentations or in-services for colleagues;
- consulting with the health care team;
- engaging in discussions about current RT practice with fellow RTs and students, as well as patients/clients, family members and un-paid caregivers.

This practice guideline provides information on the standard of practice related to the responsibilities of RTs when providing education. These principles apply when providing education in any setting, including:

- other health care providers (nurses, physicians, etc.);
- RTs and other health profession students; and
- patients/clients and their families.

For example…

Home Care RT providing education to staff in a long-term care facility

RTs who are employed by home care companies are often contacted to provide education to interdisciplinary groups in long-term care facilities on topics like non-invasive ventilation and suctioning. In these circumstances, the RT is not required to ensure competency by the end of the learning session, or guarantee that a mechanism will be in place to ensure ongoing competency after leaving the facility. The purpose of the learning session in this case is to provide a forum for introduction and/or review of the skill(s). The objectives of the teaching session should be clearly defined at the beginning of the learning session. This will minimize any possible confusion related to the training purposes and will help define the learning outcomes that participants should expect.

RT Educators

While all RTs are expected to educate others by sharing their knowledge, postgraduate training is required to become an official "educator". An educator is a person who specializes in the theory and practice of education. Educators have a thorough understanding of how adults learn best and creatively integrate this knowledge into the instruction and design of their education programs.

Most RTs who are educators work as instructors at respiratory therapy education facilities, and have taken postgraduate courses to gain greater knowledge of adult education principles. However, some RTs complete postgraduate certification programs that provide some additional knowledge about adult learners and prepare them to act as an educator in a specific area. Examples of some certification programs are:

- Certified Asthma Educator
- Certified Respiratory Educator; and
- Certified Tobacco Educator

General Expectations of Respiratory Therapists when Providing Education

It is essential that RTs understand there is a "shared accountability" when they provide education to those around them (e.g., patients/clients, fellow health care team member). Both the RT and the learner are responsible for their own actions, and have an accountability to the patients/clients they care for, as well as their own school, regulatory body, and other relevant stakeholders. When providing education, RTs are expected to:

1. Determine Appropriateness of Education
2. Maintain Professional Standards of Practice
3. Understand the Difference Between Educating and Delegating
4. Ensure Patient/Client Safety and Quality of Care
5. Keep Appropriate Documentation

1. Determining Appropriateness of Education

The RT must begin by carefully considering if providing education is ultimately in the best interest of the patient(s)/client(s) that they care for by:

- establishing that the procedure/task being taught is appropriate given the learner's background and experience; and
- being aware of the learner's education objectives and expectations.

There are certain circumstances where educating others would not be appropriate, such as when:

- the RT does not have the requisite competency (knowledge, skills and judgment) to perform and teach the procedure/task;
- the RT reasonably believes that the learner does not possess the requisite competencies and judgment to proceed safely; and/or
- educating someone else would place a patient/client at risk of receiving care that is below optimal standard.

Please note…

RTs can't assume that a person is competent to perform any procedure, regardless of how straightforward it appears. When there is concern that the learner is not able to obtain the competency for performing the procedure safely, the RT must reflect on the education process and learner's skill level.

If, after considering the above, you determine that the cause cannot be identified and resolved, then the education process should be discontinued.

2. Maintaining Professional Standards of Practice

RTs are expected to provide education to the best of their ability by:

- providing accurate and timely feedback to the learner;
- encouraging ongoing feedback from the learner; and
- conducting themselves in an honourable and professional manner at all time.

3. Understanding the Difference between Educating and Delegating

An education component is required for all delegations; however, not all education requires delegation. The main difference is a greater degree of accountability is placed on the educator when delegation is involved.

	Education	Delegation
What is it:	Providing instruction. May involve determining competence to perform a procedure	Providing instruction, plus the transfer of legal authority to perform a controlled act and a process to ensure initial and ongoing competence.
What it applies to:	Applicable to any procedure/activity (may or may not be a controlled act).	Controlled act procedures only.
Who may do it:	RTs who meet the conditions as described under the section on "General expectations of Respiratory Therapists when providing education".	RTs that have the authority, competence and meet the conditions required to teach.

For more information on delegation, please refer to the ***Delegation of Controlled Acts*** PPG.

4. Ensuring Patient/Client Safety and Quality of Care

Optimal patient/client care is the first and foremost consideration when providing education. The RT is expected to:

- ensure patient/client autonomy and confidentiality;
- have the requisite competency (knowledge, skills and judgment) to perform the procedure or task being taught;
- reinforce best practice standards; and
- intervene in situations where the safety or well-being of the patient/client is at risk.

5. Keeping Appropriate Documentation

Documentation is the evidence that a learning activity took place and provides details about what was involved in the education process. Records of teaching-related activities should include, at minimum:

- date and time of education;
- details of the activity/procedure that was taught;
- list of learners that took part in the education (preferably with signatures); and
- a copy of the learning package and any additional material provided to the learner.

For example…

An RT working as the only RT in a rural hospital has been asked to teach all the nurses and physicians how to manage the new BiPAP machine recently purchased by the facility. Most of the learners have never used any type of non-invasive positive pressure (NIPPV) device before, and the nurses and physicians will be expected to operate the unit when the RT is not available (i.e., evening and weekends). The RT creates a comprehensive learning package, which is presented to the staff at multiple 'Lunch & Learn' sessions (both verbally as part of the education session and as a handout). The RT kept a sign-up sheet record of all those who attended the education sessions and created step-by-step instructions of how to initiate, maintain and discontinue NIPPV, which was kept with the NIPPV unit.

A copy of the learning package, the sign-in sheets and the instruction sheets were all part of the documentation that the RT kept as a record of the education provided.

PROVIDING EDUCATION

The five (5) groups of people that RTs most commonly educate are:

1. Patients/Clients and Family Care Providers
2. Non-Regulated Health Care Professionals
3. Regulated Health Care Professionals
4. Respiratory Therapy Students
5. Other students (e.g., nursing).

1. Educating Patients/Clients and Family Care Providers

Patients/Clients and family members provide essential care in the community, including suctioning, tracheostomy maintenance, and ventilator management. When deciding whether it is safe and appropriate to provide education to a patient/client and/or their family care providers, RTs should consider the following:

- The needs of the patient/client;
- The level of knowledge, skill and judgment that is required to perform the required procedure(s) safely;
- The risks involved in performing the procedure and whether the patients/clients and/or family care providers have the ability to recognize and deal with them appropriately; and
- How competence in the procedure will be maintained.

The *Regulated Health Professions Act* (*RHPA)* has an exception that enables controlled acts to be performed by patients/clients and family members without delegation in the following circumstances, which are when:

> *(d)* ***treating a member of the person's household*** *and the act is a controlled act set out in paragraph* ***1, 5 or 6*** *of subsection 27 (2).*

Table 1: Controlled Acts Included in the *RHPA* Exceptions

***RHPA* Paragraph**	**Controlled Act**
#1	*Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.*
#5	***Administering a substance by injection or inhalation.***
#6	*Putting an instrument, hand or finger,* *i) beyond the external ear canal,* ***ii) beyond the point in the nasal passages where they normally narrow,*** ***iii) beyond the larynx,*** *iv) beyond the opening of the urethra,* *v) beyond the labia majora,* *vi) beyond the anal verge, or* *vii) into an artificial opening into the body.*

RTs are permitted to perform controlled act #5 and can perform suctioning and intubation via sections ii) and iii) in controlled act #6. RTs do not have the legislative authority to perform controlled act #1. Table 2 outlines the controlled acts authorized to RTs via the *Respiratory Therapy Act* (*RTA*) and how each relates to these exceptions in the RHPA.

Please note…

Procedures that are not controlled acts are part of the public domain (e.g., administering oral medication) and require no legislative authority to perform. For more information, please see the CRTO *Interpretation of Authorized Acts* PPG.

Important…

Administering a prescribed substance by inhalation. (RTA #5) is not included in exception and cannot be delegated.

Table 2: *Treating a member of the person's household*

Controlled Act Authorized to RTs in the *RTA*	***Treating a member of the person's household* (e.g. family member)**
1. ***Performing a prescribed procedure below the dermis.* (RTA #1; RHPA #2)**	Not included in exception, therefore cannot be performed by family member in the community unless it has been delegated.
2. ***Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx*. (RTA #2; RHPA #6 ii & iii)**	*RHPA* exception permits act to be performed by family member when treating a member of the person's household. RT may provide education.
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For example…

Non-invasive Positive Pressure Ventilation (NIPPV) (e.g.,CPAP and BiPAP)

NIPPV falls under the controlled act of *administering a substance by inhalation*. Patients who are in the hospital and preparing for discharge on a CPAP or BiPAP unit will require education on the equipment in order to apply the therapy and troubleshoot independently once at home. Since this procedure is covered by the exception under the *RHPA* described in subsection 29 (1), it does not require delegation. An RT can provide the education needed to the patient/client and family members.

For more information on the controlled acts authorized to Respiratory Therapists, please refer to the PPG on *Interpretation of Authorized Acts.*

2. Educating Non-Regulated Health Care Providers

NRHCPs (e.g., PSWs) work in a variety of practice settings, including hospitals. NRHCPs do not have any controlled acts authorized to them and require delegation for any controlled acts they perform in an acute care setting. As mentioned previously, education is an essential part of a delegation process.

The *Regulated Health Professions Act* (*RHPA)* has an exception that enables controlled acts to be performed by NRHCPs (as well as regulated health care professionals who do not have the legislative authority) without delegation in the following circumstances, when:

> *(e) assisting a person with his or her **routine activities of living** and the act is a controlled act set out in paragraph **5 or 6** of subsection 27 (2).*

Table 3: *Assisting a person with his/her routine activities of living*

Controlled Act Authorized to RTs in the *RTA*	***Assisting a person with his/her routine activities of living* (e.g. PSWs)**
1. *Performing a prescribed procedure below the dermis* (RTA #1; RHPA #2)	Not included in exception, therefore cannot be performed by NRHCP unless delegated.
2. Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx (RTA#2; RHPA #6 ii & iii)	*RHPA* exception permits performance by NRHCP if it involves an activity of daily living. RT may provide education.
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4. Administering a substance by injection or inhalation. (RTA #4; RHPA # 5)	*RHPA* exception permits performance by NRHCP if it involves an activity of daily living. RT may provide education.

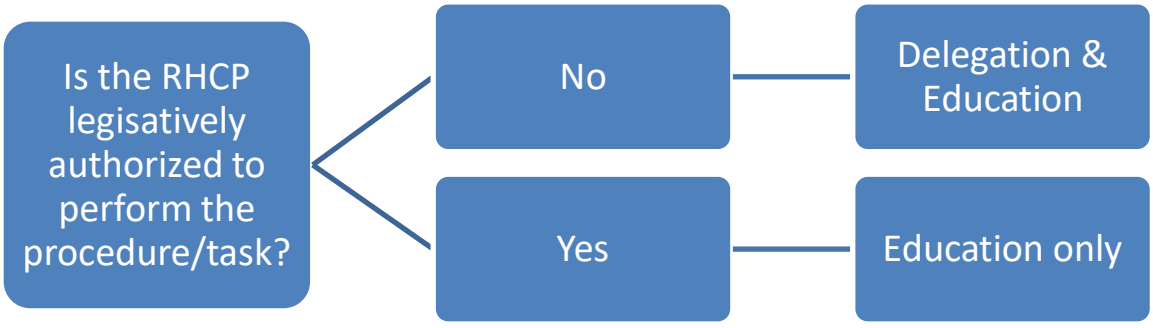
In the case of NRHCPs, delegation may or may not be required for them to perform a controlled act. The determining factor is the setting where the care is provided. In a health care setting, such as a hospital or rehabilitation centre, delegation is required and the conditions of both delegation and teaching must be met. However, if the procedure is being performed in patient/client's home, delegation is not required since it is covered by the *RHPA* exception, "*Assisting a person with his/her routine activities of living*". Therefore, delegation is not required and the RT only needs to ensure that the general expectations of education are met.

For example…

A Personal Support Worker (PSW) in a small, community hospital is responsible for taking patients/clients out on daytime excursions. It's expected that some of these patients may need to have their oxygen levels adjusted during this time, so the controlled act "*administering a substance by injection or inhalation*" will need to be delegated to the PSW. It is important to be clear that the PSW will only be performing a portion of that particular act, which is oxygen administration. Education will be included as part of the delegation process to ensure the PSW can perform the task safely.

3. Educating Regulated Health care Professional

RTs work side-by-side a variety of other Regulated Health Care Professionals (RHCPs) and are often asked to share knowledge regarding a number of procedure with other members of the team. If a controlled act is involved, delegation is sometimes requires but most often it is not. If a RHCP is "**legislatively authorized**", it means they already have that particular controlled act authorized to them via their **profession specific legislation** (e.g., Nursing Act, Physiotherapy Act). What they may need, however, is education so that they gain the competency to perform the task effectively and safely. If asked to provide education to a RHCP, the RT should consider the following:



Important…

For an up-to-date list of RHCPs and the controlled acts they are authorized to perform, please see the Federation of Health Regulatory Colleges of Ontario (FHRCO) Interprofessional Collaboration (IPC) eTool.

For example…

Critical Care Teams

Roles and responsibilities are often shared amongst team members of critical care transport teams and critical care response teams. Common team members include an RT, nurse and physician. Intubation and manual ventilation procedures may be performed as part of the work done by the team. Nurses and physicians have the legislative authority to perform these procedures and, therefore, do not require delegation. In practice however, some nurses or physicians may not be experienced in performing these activities and may require additional training. RTs have significant expertise in airway management and could provide the teaching required for these clinicians to become competent in performing these skills. In this situation it would be appropriate to teach these skills, ensuring that all general expectations of education are met.

For example…

RHCP who is not legislatively authorized

The administration of oxygen falls under the RHPA controlled act #5 "*administering a substance by injection or inhalation*", which is a controlled act authorized to RTs. However, Speech Therapists are not currently authorized to administer oxygen and would require delegation. An RT can choose to delegate this controlled act to a Speech Therapist, or the delegation can come from another RCHP who is authorized to perform the procedure (e.g., physician). The RT may only be asked to provide the education in this scenario.

4. Educating Respiratory Therapy Students

Expectations of Students in Respiratory Therapy Programs

The CRTO does not regulate respiratory therapy students as they are not (yet) Members of the CRTO. Section 9 of the RTA and the *Registration* regulation (O. Reg. 17/12) restricts the use of the term "Respiratory Therapist" (including variations and abbreviations such as RRT), in Ontario, to Members of the College. However, the CRTO wishes to provide students in respiratory therapy programs the opportunity to identify themselves in a manner that reflects the training they are undertaking. For this reason, the CRTO allows respiratory therapy students to use the title “Student Respiratory Therapist” and SRT as a designation – provided that they are enrolled in an approved respiratory therapy program and only while functioning in the role of a student. In return, the CRTO expects Student Respiratory Therapist (SRTs) to:

- clearly identify themselves by the title of “Student Respiratory Therapist” and the designation of SRT;
- understand their role and responsibilities in the provision of care and be accountable for the quality of the care they provide;
- understand and comply with the various laws that may affect their practice (e.g., RHPA, Health Care Consent Act);
- maintain patient/client confidentiality;
- ensure that all entries in a patient/client health record have been co-signed by their supervising RT when providing respiratory therapy under direct supervision;
- communicate effectively with all members of the health care team they interact with;
- know their limitations and only perform activities they are competent in and have adequate background preparation for; and
- understand when and from whom to seek help.

For more information, please see the CRTO *Registration and Use of Title* PPG.

Student Respiratory Therapists Performing Controlled Acts

The *RHPA* provides an exception permitting students to perform controlled acts provided they are "*fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession*".

This means that Student Respiratory Therapists (SRTs) are permitted to perform controlled acts authorized to Respiratory Therapists – provided they do so while functioning as a student under the supervision or direction of a CRTO Member. The supervision or direction by a Member may be direct or indirect. For more information, please see the CRTO *Supervision* Policy and the CRTO *Registration of Use of Title* PPG.

For example…

An SRT is going to intubate for the first time under the direct supervision of an RRT. The SRT is legislatively authorized to intubate (via the exception in the RHPA), and does not require delegation for this activity or any other controlled act authorized to RTs. However, the SRT needs education from the RRT in order to perform the task safely and competently. Both the SRT and RRT are accountable for their individual actions in this scenario. For more information, please see the section on **Shared Accountability when Educating** at the end of this PPG.

Direct Supervision of SRTs and Documentation

Where an SRT is performing procedures under direct supervision, the supervising RRT and the SRT are expected to do the following:

- document that the student has performed the procedure(s) under “direct supervision” in the patient/client’s health record;
- provide complete documentation of the patient contact in the patient/client health record; and
- ensure that the supervising RRT cosigns any entries made by a student in the patient/client record.

Remember that anyone reading the documentation must be able to clearly identify that the requirements of “direct supervision” have been met. Also, keep in mind that the student’s signature and that of the cosigning RT verifies the information provided and assures that the record of activity, assessment, behaviour or procedure is both accurate and complete.

Please note…

GRTs must perform controlled acts authorized to RTs under General Supervision. This is due to the nature of their certificate of registration with the CRTO (i.e., temporary certificate with terms, conditions and limitations). Therefore, GRT's are not permitted to supervise SRTs in the performance of any intervention that falls under a controlled act authorized to respiratory therapists (e.g., oxygen administration). For more information please see *Registration and Use of Title* PPG.

Personal Relationships between Registered Respiratory Therapists and Student Respiratory Therapists

When RTs are involved in providing education to SRTs there is an inherent power imbalance – whether directly as a faculty member/clinical instructor, or indirectly as a supervising staff RT. This power imbalance exists because the RRT has status and influence over the SRT, which may affect the success of the student. The CRTO strongly discourages personal relationships between CRTO members (who are directly or indirectly involved in the student's education) and SRTs. In many circumstances such a personal relationship will amount to unprofessional conduct. A faculty member or clinical instructor will continue to have influence over a student until graduation, but a staff RT at a certain hospital or facility will likely only have influence as long as the student is on rotation in that environment. Once an influence over the student no longer exists, a CRTO member may form a relationship with their former student.

For more information, please see the *Abuse Prevention and Awareness* PPG.

ADDITIONAL CONSIDERATIONS

Shared Accountability when Educating

During the educational process, both the RT and learner are responsible for their own actions, while sharing accountability for the outcome of this knowledge exchange. The RT providing the education is responsible for determining whether it is appropriate to teach the particular procedure, as well as deciding how best to transfer the knowledge and evaluate the learner's competence. Additionally, the RT is accountable to their patients/clients, their employer and to the CRTO. It is the learner's responsibility to only engage in tasks they have the requisite competencies for, and are also often accountable to other entities (e.g., student RTs have accountability to their educational institution).

Before permitting anyone (including a student) to perform an activity, it's essential that the RT ensures they have assessed the potential harm associated with the procedure. They must also determine whether it's appropriate to allow an individual to perform the activity after considering the individual's existing competencies.

GLOSSARY

Authorized Acts - A controlled act, or portion of a controlled act, that is authorized within a health profession Act for a health professional to perform [there are 5 acts authorized to Respiratory Therapists by the Respiratory Therapy Act, that are created from 3 controlled acts defined in the *RHPA*]

Members – is a respiratory therapist who is registered with the CRTO; including Graduate Respiratory Therapists (GRT), Practical (Limited) Respiratory Therapists (PRT) and Registered Respiratory Therapists (RRT).

Published August 2000

Revised September 2005

Revised February 2008

Draft Respiratory Therapists Providing Education Professional Practice Guideline to replace the current Respiratory Therapists Providing Education Professional Practice Guideline

College of Respiratory Therapists of Ontario

Professional Practice Guideline

Respiratory Therapists Providing Education

College of Respiratory Therapists of Ontario (CRTO) publications contain practice parameters and standards which should be considered by all Ontario Respiratory Therapists (RTs) 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.

It is important to note that employers may have policies related to an RT's authority to perform certain procedures; including controlled acts, authorized acts and acts that fall within the public domain. 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.

March 2015

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.

Table of Contents

INTRODUCTION

Respiratory Therapists (RTs) possess a unique body of knowledge, which when shared with others, promotes the best possible outcome for patients, colleagues, students, and the public. ~~and therefore, have the opportunity to share and enable other others to develop expertise and confidence.~~ In one way or another, all RTs provide education to those around them. However, it is important to differentiate between RTs who provide education and RT educators.

RTs Who Provide Education

The ~~*Therapeutic & Professional Relationships*~~ Professional Responsibilities standard in the College of Respiratory Therapists of Ontario (CRTO) *Standards of Practice* outlines the expectations for all Respiratory Therapists (RTs) who are **Members** of the CRTO. ~~to RT's *"share appropriate knowledge and expertise with colleagues, peers, patients/clients, students and others".*~~

RT's "are responsible for educating other healthcare team members, including students regarding respiratory health and the role of RTs". In general, this means that RTs in all practice settings have some role in providing education. ~~with a professional obligation to share knowledge and expertise with others.~~

The CRTO Standards of Practice also articulates the expectation that RTs ~~*"promote respiratory health and patient/client independence through education, coaching and counseling".*~~ *"deliver information in a manner that acknowledges individual diversity and health literacy and facilitates patients'/clients' understanding of pertinent information".* RTs accomplish this by:

- demonstrating best practices to students;
- providing presentations or in-services for colleagues;
- consulting with the health care team;
- engaging in discussions about current RT practice with fellow RTs and students, as well as patients/clients, family members and un-paid caregivers.

This practice guideline provides information on the standard of practice related to the responsibilities of RTs when providing education. These principles apply when providing education in any setting, including:

- other health care providers (nurses, physicians, etc.);
- RTs and other health profession students; and
- patients/clients and their families.

For example…
Home Care RT providing education to staff in a long-term care facility
RTs who are employed by home care companies are often contacted to provide education to interdisciplinary groups in long-term care facilities on topics ~~like~~ such as non-invasive ventilation and suctioning. In these circumstances, the RT is not required to ensure competency by the end of the learning session, or guarantee that a mechanism will be in place to ensure ongoing competency after leaving the facility. The purpose of the learning session in this case is to provide a forum for introduction and/or review of the skill(s). The objectives of the teaching session should be clearly defined at the beginning of the learning session. This will minimize any possible confusion related to the training purposes and will help define the learning outcomes that participants should expect.

RT Educators

While all RTs are expected to educate others by sharing their knowledge, postgraduate training is often required to become an official "educator". An educator is a person who specializes in the theory and practice of education. Educators have a thorough understanding of how adults learn best and creatively integrate this knowledge into the instruction and design of their education programs.

Most RTs who are educators work as instructors at respiratory therapy education facilities, and have taken postgraduate courses to gain greater knowledge of adult education principles. However, some RTs complete postgraduate certification programs that provide some additional knowledge about adult learners and prepare them to act as an educator in a specific area. Examples of some certification programs are:

- Certified Asthma Educator
- Certified Respiratory Educator; and
- Certified Tobacco Educator

General Expectations of Respiratory Therapists when Providing Education

It is essential that RTs understand there is a "shared accountability" when they provide education to those around them (e.g., patients/clients, fellow health care team member). Both the RT and the learner are responsible for their own actions, and have an accountability to the patients/clients they care for, as well as their own school, regulatory body, and other relevant stakeholders. When providing education, RTs are expected to:

1. Determine Appropriateness of Education
2. Maintain Professional Standards of Practice
3. Understand the Difference Between Educating and Delegating
4. Ensure Patient/Client Safety and Quality of Care
5. Keep Appropriate Documentation

1. Determining Appropriateness of Education

The RT must begin by carefully considering if providing education is ultimately in the best interest of the patient(s)/client(s) that they care for by:

- establishing that the procedure/task being taught is appropriate given the learner's background and experience; and

- being aware of the learner's education objectives and expectations.

There are certain circumstances where educating others would not be appropriate, such as when:

- the RT does not have the requisite competency (knowledge, skills and judgment) to perform and teach the procedure/task;

- the RT reasonably believes that the learner does not possess the requisite competencies and judgment to proceed safely; and/or

- educating someone else would place a patient/client at risk of receiving care that is below optimal standard.

Please note…

RTs can't assume that a person is competent to perform any procedure, regardless of how straightforward it appears. When there is concern that the learner is not able to obtain the competency for performing the procedure safely, the RT must reflect on the education process and learner's skill level.

If, after considering the above, you determine that the cause cannot be identified and resolved, then the education process should be discontinued.

2. Maintaining Professional Standards of Practice

RTs are expected to provide education to the best of their ability by:

- providing accurate and timely feedback to the learner;
- encouraging ongoing feedback from the learner; and
- conducting themselves in an honorable, ethical, and professional manner at all times.

3. Understanding the Difference between Educating and Delegating

An education component is required for all delegations; however, not all education requires delegation. The main difference is a greater degree of accountability is placed on the educator when delegation is involved.

	Education	Delegation
What is it:	Providing instruction. May involve determining competence to perform a procedure	Providing instruction, plus the transfer of legal authority to perform a controlled act and a process to ensure initial and ongoing competence.
What it applies to:	Applicable to any procedure/activity (may or may not be a controlled act).	Controlled act procedures only.
Who may do it:	RTs who meet the conditions as described under the section on "General expectations of Respiratory Therapists when providing education".	RTs that have the authority, competence and meet the conditions required to teach.

For more information on delegation, please refer to the ***Delegation of Controlled Acts*** PPG

4. Ensuring Patient/Client Safety and Quality of Care

Optimal patient/client care is the first and foremost consideration when providing education. The RT is expected to:

- ensure patient/client autonomy and confidentiality;
- have the requisite competency (knowledge, skills and judgment) to perform the procedure or task being taught;
- reinforce best practice standards; and
- intervene in situations where the safety or well-being of the patient/client is at risk.

5. Keeping Appropriate Documentation

Documentation is the evidence that a learning activity took place and provides details about what was involved in the education process. Records of teaching-related activities should include, at minimum:

- date and time of education;
- details of the activity/procedure that was taught;
- list of learners that took part in the education (preferably with signatures); and
- a copy of the learning package and any additional material provided to the learner.

For example…

An RT working as the only RT in a rural hospital has been asked to teach all the nurses and physicians how to manage the new BiPAP machine recently purchased by the facility. Most of the learners have never used any type of non-invasive positive pressure (NIPPV) device before, and the nurses and physicians will be expected to operate the unit when the RT is not available (i.e., evening and weekends). The RT creates a comprehensive learning package, which is presented to the staff at multiple 'Lunch & Learn' sessions (both verbally as part of the education session and as a handout). The RT kept a sign-up sheet record of all those who attended the education sessions and created step-by-step instructions of how to initiate, maintain and discontinue NIPPV, which was kept with the NIPPV unit.

A copy of the learning package, the sign-in sheets and the instruction sheets were all part of the documentation that the RT kept as a record of the education provided.

PROVIDING EDUCATION

The five (5) groups of people that RTs most commonly educate are:

1. Patients/Clients and Family Care Providers
2. Non-Regulated Health Care Professionals
3. Regulated Health Care Professionals
4. Respiratory Therapy Students
5. Other students (e.g., nursing).

1. Educating Patients/Clients and Family Care Providers

Patients/Clients and family members provide essential care in the community, including suctioning, tracheostomy maintenance, and ventilator management. When deciding whether it is safe and appropriate to provide education to a patient/client and/or their family care providers, RTs should consider the following:

- The needs of the patient/client;
- The level of knowledge, skill and judgment that is required to perform the required procedure(s) safely;
- The risks involved in performing the procedure and whether the patients/clients and/or family care providers have the ability to recognize and deal with them appropriately; and
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The *Regulated Health Professions Act* (*RHPA)* has an exception that enables controlled acts to be performed by patients/clients and family members without delegation in the following circumstances, which are when:

> *(d)* ***treating a member of the person's household*** *and the act is a controlled act set out in paragraph* ***1, 5 or 6*** *of subsection 27 (2).*

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RTs are permitted to perform controlled act #5 and can perform suctioning and intubation via sections ii) and iii) in controlled act #6. RTs do not have the legislative authority to perform controlled act #1. Table 2 outlines the controlled acts authorized to RTs via the *Respiratory Therapy Act* (*RTA*) and how each relates to these exceptions in the RHPA.

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Controlled Act Authorized to RTs in the *RTA*	***Treating a member of the person's household* (e.g. family member)**
1. *Performing a prescribed procedure below the dermis.* (RTA #1; RHPA #2)	Not included in exception, therefore cannot be performed by family member in the community unless it has been delegated.
2. *Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx*. (RTA #2; RHPA #6 ii & iii)	*RHPA* exception permits act to be performed by family member when treating a member of the person's household. RT may provide education.
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Non-invasive Positive Pressure Ventilation (NIPPV) (e.g., CPAP and BiPAP)

NIPPV falls under the controlled act of *administering a substance by inhalation*. Patients who are in the hospital and preparing for discharge on a CPAP or BiPAP unit will require education on the equipment in order to apply the therapy and troubleshoot independently once at home. Since this procedure is covered by the exception under the *RHPA* described in subsection 29 (1), it does not require delegation. An RT can provide the education needed to the patient/client and family members.

~~For more information on the controlled acts authorized to Respiratory Therapists, please refer to the PPG on *Interpretation of Authorized Acts.*~~

2. Educating Non-Regulated Health Care Providers

NRHCPs (e.g., PSWs) work in a variety of practice settings, including hospitals. NRHCPs do not have any controlled acts authorized to them and require delegation for any controlled acts they perform in an acute care setting. As mentioned previously, education is an essential part of a delegation process.

The *Regulated Health Professions Act* (*RHPA)* has an exception that enables controlled acts to be performed by NRHCPs (as well as regulated health care professionals who do not have the legislative authority) without delegation in the following circumstances, when:

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2. Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx (RTA#2; RHPA #6 ii & iii)	*RHPA* exception permits performance by NRHCP if it involves an activity of daily living. RT may provide education.
3. Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx. (RTA #3; RHPA #6 ii & iii)	*RHPA* exception permits performance by NRHCP if it involves an activity of daily living. RT may provide education.
4. Administering a substance by injection or inhalation. (RTA #4; RHPA # 5)	*RHPA* exception permits performance by NRHCP if it involves an activity of daily living. RT may provide education.

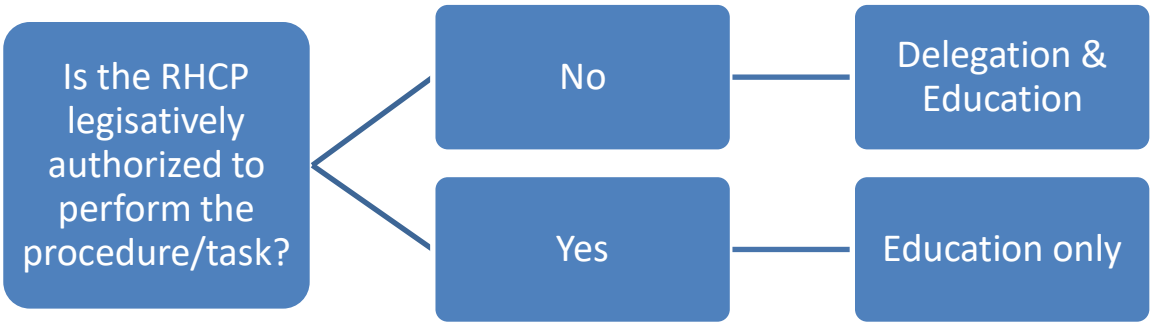
In the case of NRHCPs, delegation may or may not be required for them to perform a controlled act. The determining factor is the setting where the care is provided. In a health care setting, such as a hospital or rehabilitation centre, delegation is required and the conditions of both delegation and teaching must be met. However, if the procedure is being performed in patient/client's home, delegation is not required since it is covered by the *RHPA* exception, "*Assisting a person with his/her routine activities of living*". ~~Therefore, delegation is not required, and~~ The RT only needs to ensure that the general expectations of education are met.

For example…

A Personal Support Worker (PSW) in a small, community hospital is responsible for taking patients/clients out on daytime excursions. It's expected that some of these patients may need to have their oxygen levels adjusted during this time, so the controlled act "*administering a substance by injection or inhalation*" will need to be delegated to the PSW. It is important to be clear that the PSW will only be performing a portion of that particular act, which is oxygen administration. Education will be included as part of the delegation process to ensure the PSW can perform the task safely.

3.Educating Regulated Health care Professionals

RTs work side-by-side a variety of other Regulated Health Care Professionals (RHCPs) and are often asked to share knowledge regarding a number of procedures with other members of the team. If a controlled act is involved, delegation is sometimes required but most often it is not. If a RHCP is "**legislatively authorized**", it means they already have that particular controlled act authorized to them via their **profession specific legislation** (e.g., Nursing Act, Physiotherapy Act). What they may need, however, is education so that they gain the competency to perform the task effectively and safely. If asked to provide education to a RHCP, the RT should consider the following:



For example…

RHCP who is not legislatively authorized

The administration of oxygen falls under the RHPA controlled act #5 "*administering a substance by injection or inhalation*", which is a controlled act authorized to RTs. However, Speech Therapists are not currently authorized to administer oxygen and would require delegation. An RT can choose to delegate this controlled act to a Speech Therapist, or the delegation can come from another RCHP who is authorized to perform the procedure (e.g., physician). The RT may only be asked to provide the education in this scenario.

Important…

~~For an up-to-date list of RHCPs and the controlled acts they are authorized to perform, please see the Federation of Health Regulatory Colleges of Ontario (FHRCO) Interprofessional Collaboration (IPC) eTool.~~

For example…

Critical Care Teams

Roles and responsibilities are often shared amongst team members of critical care transport teams and critical care response teams. Common team members include an RT, nurse and physician. Intubation and manual ventilation procedures may be performed as part of the work done by the team. Nurses and physicians have the legislative authority to perform these procedures and, therefore, do not require delegation. In practice however, some nurses or physicians may not be experienced in performing these activities and may require additional training. RTs have significant expertise in airway management and could provide the teaching required for these clinicians to become competent in performing these skills. In this situation it would be appropriate to teach these skills, ensuring that all general expectations of education are met.

3. Educating Respiratory Therapy Students

Expectations of RT's

Students often gain knowledge and attitudes about professionalism through role modeling. As a result, aside from theory and clinical practice, it is important that RT's demonstrate a positive model of compassionate, respectful, and ethical care to all learners, and promote patient-centered care and collaborative relationships.

The characteristics of effective role modeling are as follows:

- Self reflection
- Clinical Excellence
- Empathy
- Communication
- Availability
- Demonstrated interest in teaching
- Respect for others
- Transparency

Expectations of Students in Respiratory Therapy Programs

The CRTO does not regulate respiratory therapy students as they are not (yet) Members of the CRTO. Section 9 of the RTA and the *Registration* regulation (O. Reg. 17/12) restricts the use of the term "Respiratory Therapist" (including variations and abbreviations such as RRT), in Ontario, to Members of the College. However, the CRTO wishes to provide students in respiratory therapy programs the opportunity to identify themselves in a manner that reflects the training they are undertaking. For this reason, the CRTO allows respiratory therapy students to use the title "Student Respiratory Therapist" and SRT as a designation – provided that they are enrolled in an approved respiratory therapy program and only while functioning in the role of a student. In return, the CRTO expects Student Respiratory Therapist (SRTs) to:

- clearly identify themselves by the title of "Student Respiratory Therapist" and the designation of SRT, ensuring informed consent is received from the patient, where applicable

- understand their role and responsibilities in the provision of care and be accountable for the quality of the care they provide;

- understand and comply with the various laws that may affect their practice (e.g., RHPA, Health Care Consent Act);

- maintain patient/client confidentiality;

- ensure that all entries in a patient/client health record have been co-signed by their supervising RT when providing respiratory therapy under direct supervision;
- communicate effectively with all members of the health care team they interact with;
- know their limitations and only perform activities they are competent in and have adequate background preparation for; and
- understand when and from whom to seek help.

For more information, please see the CRTO *Registration and Use of Title* PPG.

A student Respiratory Therapist is on summer break from school and is employed at a local hospital as aide in the RT department. While acting in this role, the student is NOT permitted to introduce themselves as an SRT, as they are not functioning in the role of a student.

Student Respiratory Therapists Performing Controlled Acts

The *RHPA* provides an exception permitting students to perform controlled acts provided they are "*fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession*".

This means that Student Respiratory Therapists (SRTs) are permitted to perform controlled acts authorized to Respiratory Therapists – provided they do so while functioning as a student under the supervision or direction of a CRTO Member. The supervision or direction by a Member may be direct or indirect. For more information, please see the CRTO *Supervision* Policy and the CRTO *Registration of Use of Title* PPG.

For example…
An SRT is going to intubate for the first time under the direct supervision of an RRT. The SRT is legislatively authorized to intubate (via the exception in the RHPA), and does not require delegation for this activity or any other controlled act authorized to RTs. However, the SRT needs education from the RRT in order to perform the task safely and competently. Both the SRT and RRT are accountable for their individual actions in this scenario. Documentation needs to reflect that the SRT was directly supervised and the supervising RRT must co-sign. For more information, please see the section on **Shared Accountability when Educating** at the end of this PPG.

Direct Supervision of SRTs and Documentation

Where an SRT is performing procedures under direct supervision, the supervising RRT and the SRT are expected to do the following:

- document that the student has performed the procedure(s) under "direct supervision" in the patient/client's health record;
- provide complete documentation of the patient contact in the patient/client health record; and
- ensure that the supervising RRT cosigns any entries made by a student in the patient/client record.

Remember that anyone reading the documentation must be able to clearly identify that the requirements of "direct supervision" have been met. Also, keep in mind that the student's signature and that of the cosigning RT verifies the information provided and assures that the record of activity, assessment, behaviour, or procedure is both accurate and complete.

Please note…
GRTs must perform controlled acts authorized to RTs under General Supervision. This is due to the nature of their certificate of registration with the CRTO (i.e., temporary certificate with terms, conditions and limitations). Therefore, GRT's are not permitted to supervise SRTs in the performance of any intervention that falls under a controlled act authorized to respiratory therapists (e.g., oxygen administration). GRT's general supervision requirement does not require co-signing of documentation. For more information please see *Registration and Use of Title* PPG.

Personal Relationships between Registered Respiratory Therapists and Student Respiratory Therapists

When RTs are involved in providing education to SRTs there is a power differential ~~inherent power imbalance~~ – whether directly as a faculty member/clinical instructor, or indirectly as a supervising staff RT. This power imbalance exists because the RRT has status and influence over the SRT, which may affect the success of the student. The CRTO strongly discourages personal relationships between CRTO members (who are directly or indirectly involved in the student's education) and SRTs. In many circumstances such a personal relationship will amount to unprofessional conduct. A faculty member or clinical instructor will continue to have influence over a student until graduation, but a staff RT at a certain hospital or facility will likely only have influence as long as the student is on rotation in that environment. Once an influence over the student no longer exists, a CRTO member may form a relationship with their former student.

At all times, the RT must demonstrate professional behavior in their interactions with not only students, but colleagues, patients, and families. It is important that inappropriate or disruptive actions be avoided, including language, actions, and inactions that do not represent the professions expectations of the standards of practice.

For more information, please see the *Abuse Prevention and Awareness* PPG.

ADDITIONAL CONSIDERATIONS

Shared Accountability when Educating

During the educational process, both the RT and learner are responsible for their own actions, while sharing accountability for the outcome of this knowledge exchange. The RT providing the education is responsible for determining whether it is appropriate to teach the particular procedure, as well as deciding how best to transfer the knowledge and evaluate the learner's competence. Additionally, the RT is accountable to their patients/clients, their employer and to the CRTO. It is the learner's responsibility to only engage in tasks they have the requisite competencies for, and are also often accountable to other entities (e.g., student RTs have accountability to their educational institution). RT's must ensure that they are identified and available to assist learners when they are not being directly supervised (e.g. not in the same room). If necessary, RT's must also ensure that an appropriate alternative supervisor is available and agreeable to assist.

Before permitting anyone (including a student) to perform an activity, it's essential that the RT ensures they have assessed the potential harm associated with the procedure. They must also determine whether it's appropriate to allow an individual to perform the activity after considering the individual's existing competencies.

GLOSSARY

Authorized Acts - A controlled act, or portion of a controlled act, that is authorized within a health profession Act for a health professional to perform [there are 5 acts authorized to Respiratory Therapists by the Respiratory Therapy Act, that are created from 3 controlled acts defined in the *RHPA*]

Members – is a respiratory therapist who is registered with the CRTO; including Graduate Respiratory Therapists (GRT), Practical (Limited) Respiratory Therapists (PRT) and Registered Respiratory Therapists (RRT).

References

College of Nurses of Ontario. (2002).Professional Standards. Retrieved from: https://www.cno.org/globalassets/docs/prac/41006_profstds.pdf

College of Physicians and Surgeons of Ontario (2021) Professional Responsibilities in Medical Education. Retrieved from: https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Responsibilities-in-Medical-Education

Health.Vic (2020) The Best Practice Clinical Learning Environment Framework. Retrieved from: BPCLE Framework - March 2013 - PDF.pdf

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

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AGENDA ITEM # 4.6 **September 24, 2021**

From:	*Kelly Arndt RRT, Quality Practice Coordinator*
Topic:	*Draft Revised Documentation Professional Practice Guideline (PPG)*
Purpose:	*For Decision*
Strategic Focus:	*Protecting patient information and privacy by ensuring Respiratory Therapists understand their responsibilities when documenting.*
Attachment(s):	Appendix A - Current Documentation PPG Appendix B – Revised Documentation PPG

PUBLIC INTEREST RATIONALE:

This PPG ensures that Respiratory Therapists in Ontario understand the professional responsibilities and requirements set out by the CRTO and legislation, regarding documentation, the handling of patient information and privacy.

ISSUE:

Previously revised in June 2015, the Documentation PPG has been reviewed and updated to expand on current documentation standards and expectations.

BACKGROUND:

This PPG sets out the direction and expectations of RT's when documenting in several methods (e.g., electronic), formats, (e.g., templates) and practice settings (e.g., while supervising, or on transport), and the potential implications if the standards are not met or privacy is breached.

ANALYSIS:

Summary of Changes
This PPG has been updated to expand on the definition of patient/client contact, corrections

to the medical record, and the use of dictation and templates. It also outlines the expectations for documenting across different practice settings, and the importance of understanding how to document while supervising. A jurisdictional and regulatory scan was conducted to confirm the content of the document is current and aligned with all relevant legislation and regulations.

RECOMMENDATION:

It is recommended that the CRTO Council review and approve the revised Documentation PPG for circulation for feedback from members and stakeholders as per the attached motion.

NEXT STEPS:

If the motion is approved, the PPG will be circulated for public consultation and review. A final draft will be presented at the December 2021 Council meeting.

AGENDA ITEM # 4.6

Motion Title:	*Draft Revised Documentation Professional Practice Guideline*
Date of Meeting:	*September 24, 2021*

It is moved by _____ and seconded by _____ that:

Council approves the *Draft Revised Documentation Professional Practice Guideline* for circulation and feedback. (A copy is attached as Appendix B to this motion within the materials of this meeting).

Current Documentation Professional Practice Guideline

College of Respiratory Therapists of Ontario Professional Practice Guideline

Documentation

College of Respiratory Therapists (CRTO) publications contain practice parameters and standards which should be considered by all Ontario Respiratory Therapists in the care of their 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.

> It is important to note that employers may have policies related to an RT's authority to perform certain procedures; including controlled acts, authorized acts and acts that fall within the public domain. 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.

June 2015

The words and phrases in **bold** lettering can be cross referenced in the **Glossary** at the end of the document.

Table of Contents

DOCUMENTATION DEFINED

This Professional Practice Guideline (PPG) describes the professional and legal obligations of **CRTO Members** with respect to **Personal Health Records** (PHR) and documentation.

For the purpose of this PPG, the term Personal Health Record' or "PHR" refers to the record of clinical care provided to the patient/client, including (but not limited to):

- flow-sheets;
- progress notes;
- laboratory results;
- medical orders; and
- monitoring strips.

The term 'Documentation' refers not only to what is recorded in the PHR but also in:

- equipment maintenance records;
- transfer of accountability (TOA) reports;
- worksheets; and
- adverse event/critical incident reports.

There are various pieces of legislation that pertain to documentation, including (but not limited to):

- *Public Hospitals Act*;
- *Independent Health Facilities Act*;
- *Long Term Care Act*;
- *Laboratory Licensing Act*;
- *Personal Health Information Protection Act (PHIPA)*;
- *Personal Information Protection and Electronic Documents Act* (*PIPEDA*);and
- *Excellent Care for All Act*.

Myth:

"*Only the information contained within a patient's chart can be used in a court of law".*

Fact:

All patient/client information that is either electronically or paper generated is part of the personal health record and can potentially be used in a court of law.

Please note…

In addition to the CRTO standards of practice and relevant legislative requirements, Members are also accountable to adhere to their employer's policies.

Along with government legislation, there are other entities that Respiratory Therapists (RTs) are accountable to regarding documentation; namely their employer and the CRTO. Employers often have their own specific expectation regarding how their staff should chart in the patient's PHR (e.g., **narrative charting**, **charting by exception**, **problem-oriented charting**, **focus charting**).

The CRTO's *Standard of Practice* outlines the expectation of RTs when managing therapeutic and/or professional relationships, which states that:

> "*The RT appropriately manages these therapeutic and/or professional relationships by documenting all patient/client contacts as soon as possible, including the transcription of orders*".

This *Documentation* PPG is intended to provide Members with information on the CRTO's expectations related to documentation. The CRTO has also developed a number of other relevant PPGs that may have complementary and overlapping information related to documentation, such as:

- *Interpretation of Authorized Acts;*
- *Delegation of Controlled Acts;*
- *Responsibilities Under Consent Legislation;*
- *Responsibilities of Members as Educators;* and
- *Orders for Medical Care*.

Charting Styles

RTs may select any style of charting that fits with their practice, provided that it adheres to both the CRTO's expectation regarding documentation and their employer's requirements. Examples of different charting styles are:

- DARP (Data, Action/Analysis, Response, Plan)
- SOAP/SOAPIE(R) (Subjective, Objective Data, Assessment, Plan, Intervention, Evaluation, Revision);
- Narrative charting, which includes progress notes and flow-sheets; and
- Charting by Exception

CRTO Members are encouraged to work with their employers and health records department to ensure that all the requisite documentation standards and requirements are met.

The Purpose of Documentation

Communication

The primary purpose of documentation is to facilitate ongoing communication that supports the continuity, quality, and safety of care. As a key mode of communication, any health care provider reading the PHR must be able to understand what has taken place, who was involved and what the outcome for the patient/client was. An accurate and comprehensive record of the patient status, interventions and responses helps to facilitate team decision-making regarding the ongoing treatment plan.

Evidence of Care

Documentation also serves as written evidence of the care provided to the patient/client. Complete, accurate and objective documentation is important for a number of reasons; one of which is that it provides essential evidence that is often required in legal proceedings (e.g., civil court), as well as the CRTO's complaints and discipline process.

Research & Quality Improvement

Aggregate data collected from a patient's PHR (e.g., chart audits; length of stay (LOS) audits) provides valuable information for health research activities. This research, in turn, drives a number of Continuous Quality Improvement (CQI) initiatives (e.g., Asthma Care Pathways) that are aimed at improving health care outcomes for all patients/clients.

The Principles of Documentation

Documentation is effective when it enables members of a patient/client's health care team to have access to the information needed to deliver optimal patient/client care (for both present and future needs). Regardless of the practice setting (ICU, home care, emergency, outpatient clinic**, primary care**, operating room (OR), diagnostics, research), the principles of PHR documentation are the same. The CRTO acknowledge the difficulties often associated with documenting in areas such as the OR, emergency and home care. However, we encourage all CRTO Members to work with their employer in order to find solutions to these challenges.

Effective documentation forms the basis of any PHR and must be:

- Clear, concise, comprehensive and courteous;
- Accurate;
- Relevant;
- Objective;
- Permanent;
- Legible;
- Chronological;
- Timely; and
- Entered in a manner that prevents or deters alteration.

For example…

If three (3) attempts are required in order to successfully intubate a patient, then all three (3) attempts should be documented.

Patient/Client Contact Defined

The professional standard of practice is that <u>every contact between an RT and a patient/client must be documented.</u> A patient/client contact can include contact for the purposes of:

- performing an examination, diagnostic procedure, therapeutic intervention; or
- providing education to a patient/client and/or their family, caregiver or advocate.

For example…

Conferring with other members of the health care team (including the patient/client's family members) regarding their orders or medical status is also considered to be a patient/client contact.

It is important to note that patient/client contact includes not only direct patient/client care, but also indirect contact regarding a specific patient/client, such as communication via:

- Telephone;
- Fax
- Regular mail
- Email
- Text messaging
- Social media contacts (e.g., Facebook™, Twitter™)*****
- Video conference (e.g., Skype™)
- Telemedicine (e.g., Ontario Telemedicine Network™)

*For information on the use social media in professional practice, please view the elearning module *Pause Before You Post: Social Media Awareness for Regulated Healthcare Professionals*.

Confidentiality & Privacy of Personal Health Records

All RTs must respect and protect patient /client confidentiality and privacy in every aspect of their practice. RTs can only share patient/client information with the consent of the patient/client, or as required where permitted by law. Personal health information should only be shared within the **"circle of care"** in the following circumstances:

- If reasonably necessary for the provision of health care (providing information to another member of the health care team);
- If required by law (e.g., as part of an investigation under the *Regulated Health Professions Act; reporting of suspected child abuse under the Child and Family Services Act)*; or
- To disclose a risk of harm as enabled *PHIPA* under section 40 (1) *Disclosures related to risks,* which states that:

Circle of Care – Sharing Personal Health Information for Health Care Purposes

The term "circle of care" is not defined in *PHIPA*. However, 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.

40. (1) A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the

purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

PHIPA provides specific guidance for handling the collection, use and disclosure of personal health information by information custodians. RTs who are employees of hospitals, or most other facilities, are not custodians but "**agents**" of organizational custodians. Therefore, it is the organizational custodian (employer) who is responsible for developing policies and procedures for the collection, use, disclosure and protection of personal health information under *PHIPA*, and for ensuring compliance. As an agent, the RT must comply with the custodian's privacy practices when acting on the custodian's behalf, unless otherwise permitted by law.

RTs who are self- employed or are employed by others who are not **health information custodians** (e.g., an insurance company, a school board, industry) are considered to be health information custodians, and therefore responsible for developing a privacy policy and ensuring compliance with *PHIPA.*

Members are reminded that confidentiality is not limited to sharing of health records with others, and should consider other potential breaches, such as:

- Discussing a patient/client in a public place such as elevator/cafeteria;
- Viewing a patient's health record without authorization (including your own or that of a family member); and
- Leaving a patient's health record unattended where it can be viewed by others (including a computer screen).

Please note…

"*Giving information about a patient or client to a person other than the patient or client or his or her authorized representative except with the consent of the patient or client or his or her authorized representative or as required by law*" is considered to be professional misconduct.

(s.11 *Professional Misconduct*, O.Reg. 753/93).

Members should take extra care when faxing and receiving faxes containing personal health and other confidential information by ensuring:

- There is a confidentiality message on the fax cover sheet indicating that the information is confidential and if received in error the sender should be contacted and the fax destroyed securely without being read;
- The fax number is confirmed by the recipient and double-checked by sender;
- Recipients are called in advance when a highly confidential fax is being transmitted;
- Receipt of fax is confirmed by the recipient;
- The fax machine is securely located;
- Incoming faxes are distributed on arrival;
- Outgoing fax cover sheets are marked “confidential”; and
- Any outgoing fax is collected after transmission.

Please note…

When transporting confidential PHRs (e.g., from a home care company’s office to patient/client homes), Members should ensure that PHRs are kept out of sight and that vehicles are securely locked.

ELEMENTS OF DOCUMENTATION

Content of the Patient/Client Personal Health Record

Unless it is inconsistent with other legislation covering the health record, an acceptable patient/client's health record includes the following:

- Unique patient/client Identifiers, such as the patient/client's name and home address;

- Most responsible physician(s) (MRP) or other health professional(s), such as the name of the primary care physician;

- Reason for referral and diagnosis, if applicable; and

- Clinically relevant information regarding the patient/client, such as the date and time for each patient/client contact.

Inaccurate, Incomplete or Falsified Documentation

Documentation, or the lack of it, often plays a significant role in legal matters surrounding health care. In cases that are referred to the CRTO's ICRC, it has been noted that the amount of documentation is frequently not sufficient to accurately reflect what took place. All too often, there is little or no record of event or the RTs role.

Please note…

There have been a number of cases brought to the CRTO's attention where an RT has intentionally falsified a patient/client's PHR. This is a very serious offense and it is essential that Members understand that the following is considered to be professional misconduct:

"Falsifying a record relating to the member's practice". (s.16 *Professional Misconduct*, O.Reg. 753/93).

Electronic Health Records (EHR)

Electronic Health Records (EHR) are electronic version of the paper chart, and therefore, are subject to the same professional regulations and standards as paper records (Paterson, 2013). EHRs often differ from one organization to another; however, they share some common elements:

- Unique identifiers (login and electronic signature);
- Audit trail to prevent alternation;
- Mechanisms to ensure security, privacy and confidentiality;
- System for backup and storage of data; and
- Process for sharing and transferring information.

Electronic Communication

Electronic communication includes media such as email, text messaging, social media contact (e.g., Facebook™, Twitter™), video conference (e.g., Skype™; and telemedicine (e.g., Ontario Telemedicine Network™). These methods are becoming an increasingly popular way of interacting with patients/clients and family members and, as mentioned previously, are considered to be a patient/client interaction. Therefore, this type of contact must also be documented according to the same principles and standards as other forms of documentation. In addition, measures must be taken to protect the safety and security of this confidential information, such as:

- Keeping login information confidential and changing this information to align with your employer's policy;
- Encrypting emails and/or other documents being transferred electronically that contains personal health or other confidential information.

Medical Directives and RT Protocols

If RTs are providing care under the authority of a **medical directive**, it is important to reference this in the patient/client's PHR. It is a good idea to state the name of the medical directive and any corresponding number (e.g. Mechanical Ventilation Medical Directive, #00-001).

For more information, please see the CRTO *Medical Directives and the Ordering of Controlled Acts* Positon Statement.

Retention of Personal Health Records

Members who are employed in Ontario hospitals should be aware that the *Public Hospital's Act* states that patient/client health records must be maintained for at least 10 years from the date of last entry in the record. In addition, the health records of patients/clients who were under the age 18 at the time of the last entry ought to be retained for a minimum of 10 years from the day the patient/client turns 18.

RTs working in other practice settings are encouraged to confirm their employer's policies regarding record retention and to refer to legislation that outlines record retention provisions.

Abbreviations

To be understandable, records must use standard abbreviations and be correctly spelled. It is acceptable to use an abbreviation where it is spelled out in full the first time it is used in a notation. Whenever numbers are used, make sure units are included where needed to ensure there is no potential for misinterpretation. When referring to drugs and drug dosages you must always include the units along with any numbers.

Please note…

Abbreviations may vary among different practice environments. It is the Member's responsibility to ensure that the abbreviations being used are accepted in the facility where the record is being used. The CRTO does not provide a list of acceptable abbreviations.

DOCUMENTATION STANDARDS

Complete, accurate, objective and timely documentation is essential to the continuity of care and is the primary mode of communication among health professionals.

There are seven (7) basic standards related to documentation based on the expectation that anyone reading the patient/client's PHR should be able to clearly determine:

1. To whom it happened
2. When it happened
3. What happened
4. Where it happened
5. Why it happened
6. The result of what happened
7. By whom it happened

With respect to PHRs, this means that no matter what type or kind of charting is used at a particular facility, anyone reviewing the chart must be able to determine that the above standards have been met. An employer's policies and procedures related to documentation should support the seven standards, as outlined above.

Applying the Documentation Standard

I. To Whom it Happened

1) The standard is that anyone reading the documentation must clearly be able to identify the patient/client who was the recipient of the health care services. Therefore, the PHR must contain Unique Patient/Client Identifiers**,** such as:

   - Patient/client's name and home address;
   - Patient/client's date of birth and gender;
   - Patient/client's health number; and
   - ID number.

2) The patient/client's PHR must also include information as to who is/are the Most Responsible Physician(s) (MRP) (or other health professional(s), if applicable) such as:

   - The name of the primary care physician and any other health care professional (e.g., Nurse Practitioner); and/or
   - The name of any admitting, attending and/or referring physician or health care professional.

3) Reason for referral and/or diagnosis.

Please note…

PHRs may become separated; therefore, it's important to ensure that required identifiers (e.g., name, date of birth, OHIP number) are on every page of the PHR and on each piece of document that pertains to that patient (e.g., ventilator flow sheet, overnight oximetry results).

II. When it happened

Documentation should be timely and chronological. Common sense suggests the more time that passes between the activity and recording it, the higher the possibility of errors. Documentation that is timely and chronological lends credibility to the accuracy of the record. The date and time must be included in all entries and must be unambiguous. The use of the 24-hour clock is encouraged.

> **Please note…**
>
> Health records must be completed as soon after the event as possible and you are obligated to complete the record before you "finish your shift". Also, do not document before giving patient/client care.

Late entries

If documenting after an amount of time has passed, the entry must clearly be identified as a late entry and should note the time of the event and the time of the late entry as well as the appropriate identification. Documenting activities out of chronological order may suggest that the record is not accurate, and for that reason is not ideal. If using paper-based PHRs, never leave blank lines for someone else to insert notes. If there are blanks in your record, remember to put a single line through the area to ensure there is not opportunity for the original record to be altered. Also, inserted text or text that extends beyond the recognized writing/recording area may also suggest that the notations were made as an afterthought or to conceal activities.

> **Please note…**
>
> A Late Entry is an entry into a record that is made more than thirty (30) minutes after the intervention occurred or when the entry is documenting events chronologically out of sequence.

III. What Happened

Clinically Relevant History

An essential component of effective documentation is a comprehensive summary of the patient/client's clinical history. This should include such information as:

- date and time for each patient/client contact;
- information about every patient/client visit and examination, assessment, intervention, diagnostic procedure performed by the Member;
- information about every clinical finding and assessment made by the Member (e.g. ABG results);
- information about all advice and instruction given by the Member to the patient/client and/or family Member, advocate or caregiver by any method (e.g. in person, telephone, email);
- information about every referral of the patient/client by the Member to another health professional ;
- a financial record if the patient/client if charged a fee;
- information about a procedure or plan of care that was commenced but not completed, including the reasons for non-completion and the original of any written consent; and/or
- any reason a patient/client provides for canceling an appointment, if applicable.

Documenting about Consent

Generally, there are three (3) situations that commonly arise regarding consent and documentation:

1. **Patient/client has provided their consent** to whoever proposed the treatment plan (usually the most responsible physician) and is someone other than the RT. This is commonly referred to as Third Party Consent. The patient/client appears to understand and agree to the plan. In this situation, the RT is not required to document consent, although in some circumstances it may be appropriate to do so. Typically, the higher risk associated with an intervention, the more likely an RT would document the consent.

Third-Party Consent

The *Health Care Consent Act* 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.

For example…

A patient/client consents to a treatment plan that includes intubation and ventilation, if required. However, a family member feels that this course of action is futile and potentially harmful. The patient/client then goes into respiratory failure and the RT intubates them. In this scenario, it is likely important for the RT to document the conversation they had with the patient regarding their previous consent to the procedure.

2. **It is unclear whether the patient has provided consent** and the RT is the one performing the procedure. In this situation, the RT is accountable for ensuring that third-party consent has been obtained. If the RT has any doubt whether informed consent has been obtained, it is their professional obligation to obtain it and to document accordingly.

For example…

A patient/client shows up with a requisition for a cardiac stress test in a business suit and seems to have no idea what the test entails. In this scenario, the RT can assume that third-party consent has not been obtained and should provide the necessary information in order to obtain informed consent.

Please note…

When employer policy requires **written consent** for a given intervention (e.g., Pulmonary Function Test), the RT must ensure that there is a signed consent prior to the intervention being initiated.

For more information please see the CRTO ***Responsibilities Under Consent Legislation*** PPG.

3. In any case where **treatment is given without obtaining consent**, RTs should document their opinions with respect to the patient/client's capacity, as well as all actions taken.

> **For example…**
>
> A patient/client arrives in Emergency obtunded and requiring intubation. They are unable to consent to the procedure; however, delaying this procedure will conceivably result in harm to the patient/client. In this scenario, it is permissible under the *HCCA* to provide the necessary treatment, but the RT should still document their opinions with respect to capacity and all actions taken to obtain consent from a substitute decision maker, if available.

Documenting Patient/Client's Decision to Not Accept a Plan of Treatment/ Intervention

Patients/clients have the right to refuse or withdraw their consent to treatment at any time – provided they are deemed to be capable of giving or withholding consent [see Responsibilities under Consent Legislation PPG]. If a patient/client chooses not to accept a proposed intervention, document the:

- date and time;
- a description of the proposed intervention and the reasons given for providing it:
- reason(s) given by the patient/client;
- information that may have been given for the proposed intervention and the possible outcomes of patient/client not receiving the proposed treatment;
- individuals that were informed about the patient's decision (e.g., prescriber); and recommendations for alternatives, if any.

If there is an immediate risk to the patient/client as a result of not receiving the intervention, the prescriber should be notified immediately but the patient/client's decision must also be adhered to and supported.

Reporting Adverse Events and Critical Incidents

Adverse events are all unintended injuries or complications that occur during the provision of health care services. Critical incidents are adverse events so severe that they result in the actual or potential loss of life, limb or physical function.

An incident report is generally an internal document that does not become part of a patient health record. However, it is a record subject to all of the standards of documentation. If you complete an incident report, it's important to remember that information about the incident should also be included in the patient/client's chart.

Please note…

The CRTO's Standards of Practice states that RTs are expected to:

- *Report and document all adverse events/near misses and intervening in situations where the safety or wellbeing of the patient/client is unnecessarily at risk.*

Cardiac arrests

Most hospitals have specific protocols and procedures for documenting cardiac and respiratory arrests. It is the RT's responsibility to accurately document their activities at these events (e.g., medication administered, defibrillation attempts, endotracheal intubation, etc.). The date, time and outcome of all interventions must be recorded.

Please note…

When signing a cardiac arrest record, it is important to understand that you are attesting to the accuracy of that record. If the arrest record needs to be modified to reflect your role at the arrest, you should ensure that the record is amended in an appropriate manner.

End of Life Documentation

As part of the health care team (and in collaboration with patients/clients and their families), RTs are often involved in some aspect of end-of-life care (e.g., answering family member's questions about what to expect when life support is withdrawn). When a patient/client is going through the process of withdrawing care, clear and accurate documentation is essential. Unfortunately, research has demonstrated that this often is not the case. For example, a 2004 study published in the *American Journal of Critical Care* found that 90 per cent of charts reviewed did not contain any documentation as to whether the patient/client was intubated or extubated at the time of withdrawal.

Some aspects that RTs should consider when documenting their involvement in end-of-life care are as follows:

- The support provided to the family in preparation for and during withdrawal of care;
- Any involvement in end-of-life discussion;
- Supportive care provided to the patient/client during withdrawal; and
- Any advance directives or expressed wishes of the patient/client.

For example…

An RT is providing to care to an individual who is in the final stage of their life and is required to take the patient/client off the ventilator and remove their ETT. In this situation, the RT's documentation should include not only these actions, but also the conversation they had with the family prior to, during and after the patient/client was taken off life support.

IV. Where it happened

The record should reference where the patient /client received the intervention unless the location is "normal" for that patient/client. For example, if a treatment was administered in a patient recreation area, or if advice was given to a patient/client over the telephone, the record should indicate this.

Point of Care Testing

Record keeping for point-of-care testing should be treated in a way consistent with the legislation and/or this guideline. Demographic information, date, time and identity and the credentials of the person performing the procedure must be documented and included directly on the test results. Results obtained from the point of care testing should be clearly distinguishable in the health record from those obtained from other sources. Records of quality control results and proficiency testing performance should be maintained for each device.

Please note…

RTs are required to document according to the same professional standards, whether they're treating an in-patient or out-patient. Whether you are taking an ABG in your hospital's ICU or in your hospital's outpatient PFT clinic, all of the standards for documentation must be met.

Practising in the community

RTs work in a wide variety of practice settings (e.g., doctor's offices, dental offices, patient education clinics). Regardless of the practice setting, all RTs are accountable for ensuring that all patient/client contacts are documented according to the required professional standards.

CRTO Members are encouraged to seek clarification from their employers regarding any requirements when using thermal paper for printing test results (for example – bedside spirometers, oximeters and other diagnostic equipment). Thermal paper degrades over time and has a relatively short shelf life. Many facilities are now stipulating that any test results printed on thermal paper should be photocopied to ensure the record is viable for the length of time it must be kept, according to legislation.

Patient/Client Transports

Documentation related to a patient/client transport should include the particulars of any interventions and/or monitoring performed during the transport and the details of the transfer of care at the end of the transport. The type of transport should also be documented (e.g. intrahospital, interhospital, air, land).

Telephone Practice

The principles and standards related to documentation of telephone practice is the same those for face-to-face practice. The following elements should be documented:

- time and date of the contact;
- location of the caller (if applicable);
- name of the patient/client and their date of birth (DOB);
- name of caller and relationship to the patient/client, and whether the patient/client has consented to the call/email;
-
- reason for the call;
- information given by the patient/client or caller;
- symptoms as described by the patient/client or caller;
- advice or information given;
- any follow-up required; and
- signature and designation.

Consider using a log book for this purpose and advocating with your employer to develop standards around telephone and email practice.

V. Why it happened

The reason or purpose of the intervention should be included in your documentation. Is the intervention a routine visit; as a result of diagnostic tests; to perform diagnostic testing; as a result of an improvement or deterioration in status; or as a result of a medical directive or an RT protocol? Why did you do what you did? If you're administering a plan of treatment, it would be appropriate to document why the plan of treatment is being initiated the first time and then only make note of "why" if there's a specific reason to.

Objective Documentation

Objective documentation consists of unbiased observations and witnessed signs that a patient/client displays, as well as symptoms that have been directly stated by the patient/client. Information documented in the PHR should be a factual representation of what actually occurred (objective), as opposed to the RT's interpretations of the events (subjective). Documenting subjective comments can be harmful to both the patient/client's well-being (can impede effective communication) and to the RT's professional reputation. Below are some examples of objective and subjective statements.

Table 1: Examples of Objective vs. Subjective Documentation

Objective	Subjective
"the patient was crying"	"the patient was sad"
"the patient complained of SOBOE and was dyspneic with movement"	"the patient appeared uncomfortable"
"the treatment was not performed because…" list the facts	"this treatment was not in the best interest of the patient"
"I informed Dr. Smith by telephone of the changes to the patient's status as charted in the flow sheet"	"the doctor is aware"

Please note…

Patients/Clients and/or their family members have a legal right to access medical records. Therefore, any personal judgements and opinions that an RT might have should not be part of a PHR.

VI. The result of what happened

It's essential that the outcome of every intervention is captured in the PHR. This gives the entire health care team the ability to know what was done and whether the intended therapy goals were met. This information is invaluable in guiding future treatment decisions, and should include such information as:

- the result of the intervention;
- the patient/client's response to the intervention;
- whether the treatment objectives were met;
- proposed plan as a result of the intervention; and
- the RT's plan for follow up, if applicable.

For example…

An RT has been asked to initiate BiPAP on a patient/client who has elevated $PaCO_2$ levels and is nearing the end of a terminal illness. Both the patient and the RT agree to the treatment plan, although the RT feels the benefits of the therapy will be limited. When documenting, it is important to include not only the intervention itself, but also the treatment goal(s) and plan (e.g., how long the patient/client will remain on BiPAP; when the treatment plan will be reassessed; how and when the RT plans to follow up on the patient/client's progress).

VII. By whom it happened

Signatures

Anyone reading the documentation must be able to clearly identify the individual performing the activity or making the recording, while making sure there is a unique identifier for that person (e.g., signature). This means that a CRTO Member should provide a signature at the end of the entry with at least a first initial, last name and professional designation (abbreviation is acceptable).

A signature (and/or initials) certifies the information provided and gives assurance that the record of activity, assessment, behaviour or procedure is accurate and complete. CRTO Members must not give permission to anyone else to sign their name to a document under any circumstances. Members also must not sign someone else's name to a document.

Please note…

If using a paper-based **signature record,** initials and professional designation are sufficient. If a signature record is not used, a printed name should be included if a signature is not easily legible.

Co-signing Documentation when Supervising Others

When an RRT is supervising another individual [usually a Student Respiratory Therapist (SRT); however, it may also be an RRT who has Terms, Conditions and Limitations (TCLs) on their certificate of registration], it is essential that the documentation accurately reflect the following:

1. What degree of supervision was provided; and
2. Who performed each task and who provided supervision.

Direct Supervision occurs when the SRT (or Member with TCLs) performs a controlled act with the RRT observing and overseeing the task. In these cases, the student (or Member with TCLs) must document in the patient/client's PHR that they have performed the procedure(s) under "direct supervision". The supervising RRT must then co-sign the entry in the patient/client PHR stating that the documented activity took place "under direct supervision". An example of direct supervision would be a supervising RRT, physically observing and guiding the performance of arterial blood gas sample being drawn by an SRT.

Please note…

The CRTO recognizes that common RT flow-sheets used in critical care areas (such as ICU and NICU) may not provide enough space for Members to explicitly state that the activity was done under direct supervision. We suggest that you may want to reference somewhere in the patient/client health record that where two (2) initials are present, this indicates that direct supervision took place.

General Supervision involves those situations where a determination has been made that the SRT (or Member with TCLs) can perform a given controlled act independently. Where activities or procedures are being done under general supervision, the supervising RRT must not co-sign the student's documentation. The reason for this is that co-signing means the RRT is attesting to the accuracy of the documentation. If they did not witness the task(s) performed, they have no absolute way of knowing if the documentation is correct. . Only the person who performed the activity/procedure or has the patient contact should document and sign the entry.

Please note…

General (indirect) Supervision requires that the supervising RRT is ready and available to be "*personally present*" within 10 minutes if assistance is required.

(CRTO *Supervision* Policy)

For example…

An RT student in their final clinical rotation is performing an arterial blood gas under "general" supervision (i.e. the supervising RT is not physically present and observing the activity). Since the activity is being done under "general" supervision in this situation (not under direct supervision), the student must sign their own documentation and the RRT should not co-sign.

Interdisciplinary Documentation

RTs very often work as part of a multidisciplinary team that collectively provides diverse and overlapping health care services. As with any well-functioning group; effective communication within and outside of the team is vital. In order to facilitate this communication, many health care facilities have moved towards more integrated, interdisciplinary documentation records.

Please note…

It is important that you DO NOT document for someone else. There may be instances when it becomes necessary to document observations on care provided by others, (e.g., a family member witnesses a patient/client fall). It has to be clear who had the first-hand knowledge of the event, who performed the activity/intervention and who recorded the activity.

ADDITIONAL CONSIDERATIONS

Documenting a Disagreement with an Order or Plan of Treatment

If an RT does not believe that a particular order or a proposed plan of treatment is in the patient/client's best interest, it is their professional responsibility not to proceed with the intervention. In addition, the RT is expected to:

- remain objective and not involve the patient/client in the disagreement, if at all possible;
- contact the prescriber to discuss the rationale for the difference of opinion, and any suggested alternative plans; and
- provide comprehensive documentation appropriately, which includes:
    - the rationale for their refusal to provide treatment;
    - when notice was provided to the prescriber and details about discussion with prescriber, if applicable; and
    - suggested alternatives, if applicable.

Withdrawal of Care/Services Due to Abuse or Violence

Withdrawing or withholding care/services from a patient is not common and only used as a last resort in a strategic plan for managing abuse/violence. However, it may become necessary if there is a significant threat or risk of serious injury to a Member of the staff, fellow patient or a visitor. Balancing the patient's interest in receiving care against the risk of harm to others is particularly difficult in situations where the care is necessary or time-sensitive. Where it becomes necessary to withdraw or withhold care/services, documentation should include the following:

- the date and time;
- the rationale for withdrawal of care/services;
- the circumstances leading up to and including the withdrawal of care/service including the information given to the patient of the action that will be taken if the behavior continues;
- how and when information relating to the withdrawal of care/services was provided to the patient/client (e.g., verbally, in writing);
- the process used by you (i.e., employer established guidelines for managing violent or abusive behavior by patients) including all attempted efforts to resolve the situation;
- the potential consequences of withdrawing care;
- the expected standards/behaviors that must be adopted by the patient/client in order to have care/services resume in the future, if applicable;
- an alternate provider of care/service or the efforts made to refer the patient to alternate providers (if appropriate); and
- who you have notified of the situation (patient/client, physician, charge nurse, police, security, etc.)

For more information and scenarios regarding the ethics of withdrawing or withholding respiratory therapy care/services, please refer to the CRTO document *A Commitment to Ethical Practice*.

GLOSSARY

Agents (of the Health Information Custodians) – is defined in the *HCCA* in relation to a health information custodian, as "*…a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian…*"

CRTO Member – is a respiratory therapist who is registered with the CRTO; including Graduate Respiratory Therapists (GRT), Practical (Limited) Respiratory Therapists (PRT) and Registered Respiratory Therapists (RRT).

Charting by Exception (CBE) –a charting system used in patient/client health records. CBE requires a detailed plan of care of care map, and includes flowsheets, graphic records and progress notes that may take the format of SOAP/SOAPIE(R) (Subjective, Objective Data, Assessment, Plan, Intervention, Evaluation, and Revision).

Focus Charting System – a charting system which includes flow-sheets, checklists and progress notes that take the format of DARP (Data, Action/Analysis, Response, and Plan).

Health Information Custodian (HIC) - defined in the *HCCA* as *"…a person or organization described in one of the following paragraphs who has custody or control of personal health information…".*

Medical Directive – is a medical order for a range of patient/clients who meet certain conditions. The medical directive is the order and should therefore meet the criteria for a valid medical order.

Narrative Charting – is when data is recorded as progress notes, supplemented with plan of care flow sheets.

Personal Health Records (PHR) -is the record kept by HICs who provide health care and may be in either a paper-based or computerized format.

Primary Care – including, but not limited, to Family Health Teams, Community Health Centres, various agencies, such as the Canadian Mental Health Agency.

Problem-oriented Charting (POHR) - a charting system which includes a plan of care, problem list and progress notes/discharge plans which take the format of "SOAP/SOAPIE" (Subjective data, Objective data, Assessment data, Plan, Intervention and Evaluation).

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Draft Documentation Professional Practice Guideline to replace the current Documentation Professional Practice Guideline

College of Respiratory Therapists of Ontario Professional Practice Guideline

Documentation

College of Respiratory Therapists (CRTO) publications contain practice parameters and standards which should be considered by all Ontario Respiratory Therapists in the care of their 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.

> It is important to note that employers may have policies related to an RT's authority to perform certain procedures; including controlled acts, authorized acts and acts that fall within the public domain. 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.

June 2015

The CRTO will update and revise every 5 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.

Table of Contents

DOCUMENTATION DEFINED

This Professional Practice Guideline (PPG) describes the professional and legal obligations of **CRTO Members** with respect to **Personal Health Records** (PHR) and documentation.

For the purpose of this PPG, the term Personal Health Record' or "PHR" refers to the record of clinical care provided to the patient/client, including (but not limited to):

- flow-sheets;
- progress notes;
- laboratory results;
- medical orders; and
- monitoring strips.

The term 'Documentation' refers not only to what is recorded in the PHR but also in:

- equipment maintenance records;
- transfer of accountability (TOA) reports;
- worksheets; and
- adverse event/critical incident reports.

There are various pieces of legislation that pertain to documentation, including (but not limited to):

- *Public Hospitals Act*;
- *Independent Health Facilities Act*;
- *Long Term Care Act*;
- *Laboratory Licensing Act*;
- *Personal Health Information Protection Act (PHIPA)*;
- *Personal Information Protection and Electronic Documents Act* (*PIPEDA*);and
- *Excellent Care for All Act*.

Myth:

"*Only the information contained within a patient's chart can be used in a court of law".*

Fact:

All patient/client information that is either electronically or paper generated is part of the personal health record and can potentially be used in a court of law.

~~**Please note…**~~

~~In addition to the CRTO standards of practice and relevant legislative requirements, Members are also accountable to adhere to their employer's policies.~~

~~Along with government legislation, there are other entities that Respiratory Therapists (RTs) are accountable to regarding documentation; namely their employer and the CRTO. Employers often have their own specific expectation regarding how their staff should chart in the patient's PHR (e.g., **narrative charting**, **charting by exception**, **problem-oriented charting**, **focus charting**~~).

The CRTO's *Standard of Practice,* which outlines the expectation of RTs when documenting ~~managing therapeutic and/or professional relationships,~~ states that:

"Patients/clients can expect that RTs keep complete, clear, timely, objective, and accurate records of the care provided and that privacy/confidentiality is protected."

> ~~"*The RT appropriately manages these therapeutic and/or professional relationships by documenting all patient/client contacts as soon as possible, including the transcription of orders*".~~

This *Documentation* PPG is intended to provide Members with information on the CRTO's expectations related to documentation. The CRTO has also developed several ~~a number of~~ other relevant PPGs that may have complementary and overlapping information related to documentation, such as:

- *Interpretation of Authorized Acts;*
- *Delegation of Controlled Acts;*
- *Responsibilities Under Consent Legislation;*
- *Responsibilities of Members as Educators;* and
- *Orders for Medical Care*.

Charting Styles

RTs may select any style of charting that fits with their practice, provided that it adheres to both the standards, expectations and requirements of both the CRTO and the employer. ~~expectation regarding documentation and their employer's standards and requirements.~~ Examples of different charting styles are:

- DARP (Data, Action/Analysis, Response, Plan)
- SOAP/SOAPIE(R) (Subjective, Objective Data, Assessment, Plan, Intervention, Evaluation, Revision);
- Narrative charting, which includes progress notes and flow-sheets; and
- Charting by Exception

CRTO Members are encouraged to work with their employers and health records department to ensure that all the requisite documentation standards and requirements are met.

The Purpose of Documentation

Communication

The primary purpose of documentation is to facilitate ongoing communication that supports the continuity, quality, and safety of care. As a key mode of communication, any health care provider reading the PHR must be able to understand what has taken place, who was involved and what the outcome for the patient/client was. An accurate and comprehensive record of the patient status, interventions and responses helps to facilitate collaborative ~~team~~ decision-making regarding the ongoing treatment plan.

Evidence of Care

Documentation also serves as written evidence of the care provided to the patient/client. Complete, accurate and objective documentation is important for many ~~a number of~~ reasons; one of which is that it provides essential evidence that is often required in legal proceedings (e.g., civil court), as well as the CRTO's complaints and discipline process.

Research & Quality Improvement

Aggregate data collected from a patient's PHR (e.g., chart audits; length of stay (LOS) audits) provides valuable information for health research activities. This research contributes to ~~in turn, drives a number of~~ Continuous Quality Improvement (CQI) initiatives (e.g., Asthma Care Pathways, readmission outcomes) that are aimed at improving health care outcomes for all patients/clients.

The Principles of Documentation

Documentation is effective when it enables members of a patient/client's health care team to have access to the information needed to deliver optimal patient/client care (for both present

and future needs). Regardless of the practice setting (ICU, home care, emergency, outpatient clinic**, primary care**, operating room (OR), diagnostics, research), the principles of PHR documentation are the same. The CRTO acknowledge the difficulties often associated with documenting in areas such as the OR, emergency, home care and patient transport. However, we encourage all CRTO Members to work with their employer ~~in order~~ to find solutions to these challenges.

Effective documentation forms the basis of any PHR and must be:

- Clear, concise, comprehensive and courteous;
- Non-discriminatory
- Accurate;
- Relevant;
- Objective;
- Permanent;
- Legible;
- Chronological;
- Identifiable, containing a signature or audit trail that identifies the author
- Timely; and
- Entered in a manner that prevents or deters alteration.

For example…

If three (3) attempts are required to successfully intubate a patient, then all three (3) attempts should be documented.

Patient/Client Contact Defined

The professional standard of practice is that every contact between an RT and a patient/client must be documented. A patient/client contact can include contact for the purposes of:

- performing an examination, diagnostic procedure, therapeutic intervention; or
- providing education to a patient/client and/or their family, caregiver or advocate.

For example…

Conferring with other members of the health care team (including the patient/client's family members) regarding their orders or medical status is also considered to be a patient/client contact.

It is important to note that patient/client contact includes not only direct patient/client care, but also indirect contact regarding a specific patient/client, such as communication via:

- Telephone;
- Fax
- Regular mail
- Email
- Electronic (including text, social media)
- Virtual (including video conference and telemedicine)
- ~~Text messaging~~
- ~~Social media contacts (e.g., Facebook™, Twitter™)*~~
- ~~Video conference (e.g., Zoom Skype™)~~
- ~~Telemedicine (e.g., Ontario Telemedicine Network™)~~

*For information on the use social media in professional practice, please view the PPG Use of Social Media by Respiratory Therapists ~~elearning module *Pause Before You Post: Social Media Awareness for Regulated Healthcare Professionals*~~.

Confidentiality & Privacy of Personal Health Records

All RTs must respect and protect patient /client confidentiality and privacy in every aspect of their practice. RTs can only share patient/client information with the consent of the patient/client, or as required where permitted by law. Personal health information should only be shared within the **"circle of care"** in the following circumstances:

- If reasonably necessary for the provision of health care (providing information to another member of the health care team);
- If required by law (e.g., as part of an investigation under the *Regulated Health Professions Act; reporting of suspected child abuse under the Child and Family Services Act)*; or
- To disclose a risk of harm as enabled *PHIPA* under section 40 (1) *Disclosures related to risks,* which states that:

~~Circle of Care – Sharing Personal Health Information for Health Care Purposes~~

Circle of Care – Sharing Personal Health Information for Health Care Purposes

circle-of-care.pdf (ipc.on.ca)

The term "circle of care" is not defined in *PHIPA*. However, 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*.

40. (1) A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

PHIPA provides specific guidance for handling the collection, use and disclosure of personal health information by information custodians. RTs who are employees of hospitals, or most other facilities, are not custodians but "**agents**" of organizational custodians. Therefore, it is the organizational custodian (employer) who is responsible for developing policies and procedures for the collection, use, disclosure, and protection of personal health information under *PHIPA*, and for ensuring compliance. As an agent, the RT must comply with the custodian's privacy practices when acting on the custodian's behalf, unless otherwise permitted by law.

RTs who are self- employed or are employed by others who are not **health information custodians** (e.g., an insurance company, a school board, industry) are considered to be health information custodians, and therefore responsible for developing a privacy policy and ensuring compliance with *PHIPA.*

Members are reminded that confidentiality is not limited to sharing of health records with others, and should consider other potential breaches, such as:

- Discussing a patient/client in a public place such as elevator/cafeteria;
- Viewing a patient's health record without authorization (including your own or that of a family member); and
- Leaving a patient's health record unattended where it can be viewed by others (including a computer screen).

Please note…

"*Giving information about a patient or client to a person other than the patient or client or his or her authorized representative except with the consent of the patient or client or his or her authorized representative or as required by law*" is considered to be professional misconduct.

(s.11 *Professional Misconduct*, O.Reg. 753/93).

While less secure and reliable, many healthcare organizations continues to rely on fax machines for the transmission of patient information. Members should take extra care when faxing and receiving faxes containing personal health and other confidential information by ensuring:

- There is a confidentiality message on the fax cover sheet indicating that the information is confidential and if received in error the sender should be contacted and the fax destroyed securely without being read;
- The fax number is confirmed by the recipient and double-checked by sender;
- Recipients are called in advance when a highly confidential fax is being transmitted;
- Receipt of fax is confirmed by the recipient;
- The fax machine is securely located;
- Incoming faxes are distributed on arrival;
- Outgoing fax cover sheets are marked “confidential”; and
- Any outgoing fax is collected after transmission.

Please note…

When transporting confidential PHRs (e.g., from a home care company’s office to patient/client homes), Members should ensure that PHRs are kept out of sight and that vehicles are securely locked.

ELEMENTS OF DOCUMENTATION

Content of the Patient/Client Personal Health Record

Unless it is inconsistent with other legislation covering the health record, an acceptable patient/client's health record includes the following:

- Unique patient/client Identifiers, such as the patient/client's name and home address;

- Most responsible physician(s) (MRP) or other health professional(s), such as the name of the primary care physician;

- Reason for referral and diagnosis, if applicable; and

- Clinically relevant information regarding the patient/client, such as the date and time for each patient/client contact.

Inaccurate, Incomplete or Falsified Documentation

Documentation, or the lack of it, often plays a significant role in legal matters surrounding health care. In cases that are referred to the CRTO's ICRC, it has been noted that the amount of documentation is frequently not sufficient to accurately reflect what took place. All too often, there is little or no record of event or the RTs role.

Please note…

There have been several ~~a number of~~ cases brought to the CRTO's attention where an RT has intentionally falsified a patient/client's PHR. This is a very serious offense, and it is essential that Members understand that the following is considered to be professional misconduct:

"Falsifying a record relating to the member's practice". (s.16 *Professional Misconduct*, O.Reg. 753/93).

Corrections to the Medical Record

When it is necessary to correct an incomplete or inaccurate medical record, RT's must:

- Maintain the incorrect information in the record, label as incorrect (e.g. a strike through) and ensure that the information remains legible
- Date and initial the additions or corrections
- Notify any health care provider who may be impacted by the incorrect information

Dictation

There are practice settings where an RT may be required to dictate their reports or chart entries. It is important that the reports generated are reviewed by the author for accuracy as soon as possible. RT's are encouraged to avoid the "dictated but not read" scenario.

Electronic Health Records (EHR)

Electronic Health Records (EHR) are electronic version of the paper chart, and therefore, are subject to the same professional regulations and standards as paper records (Paterson, 2013). EHRs often differ from one organization to another; however, they share some common elements:

- Unique identifiers (login and electronic signature);
- Audit trail to prevent alternation;
- Mechanisms to ensure security, privacy and confidentiality;
- System for backup and storage of data; and
- Process for sharing and transferring information.

Use of Templates

The use of electronic record templates, particularly those with pre-populated fields, poses risks to accurate and complete medical records. In keeping with documentation requirements, RT's must verify that all entries are accurate, complete, and free from error.

Electronic Communication

As the delivery of healthcare becomes more responsive and progressive, this type of communication has become vital. Methods such as email, text messaging, along with virtual healthcare through video conferencing platforms and telemedicine are considered to be patient/client interactions. Therefore, ~~Electronic communication includes media such as email, text messaging, social media contact (e.g., Facebook™, Twitter™), video conference (e.g., Skype™); and telemedicine (e.g., Ontario Telemedicine Network™). These methods are becoming an increasingly popular way of interacting with patients/clients and family members and, as mentioned previously, are considered to be a patient/client interaction. Therefore,~~ this type of contact must also be documented according to the same principles and standards as other forms of documentation. It is also important to document the mode of electronic communication (e.g. text, email). In addition, measures must be taken to protect the safety and security of this confidential information, such as those outlined in the CRTO Standards of Practice. RT's must "Protect against theft, loss or unauthorized use or disclosure of confidential patient/client personal information (e.g., passwords, encryption, systems for backup and storage, and processes for sharing/transferring information).

- Keeping login information confidential, passwords strong, and changing this information to align with your employer's policy;
- Sign off devices when not in use
- Using ID's, rather than patient identifiers, such as names, when communicating electronically
- Encrypting emails and/or other documents being transferred electronically that contains personal health or other confidential information.

Medical Directives and RT Protocols

If RTs are providing care under the authority of a **medical directive**, it is important to reference this in the patient/client's PHR and document the name and number of the medical directive. ~~It is a good idea to state the name of the medical directive and any corresponding number~~ (e.g., Mechanical Ventilation Medical Directive, #00-001).

For more information, please see the CRTO'sOrders for Medical Care PPG (crto.on.ca) ~~*Medical Directives and the Ordering of Controlled Acts* Positon Statement.~~

Retention of Personal Health Records

Members who are employed in Ontario hospitals should be aware that the *Public Hospital's Act* states that patient/client health records must be maintained for at least 10 years from the date of last entry in the record. In addition, the health records of patients/clients who were under the age 18 at the time of the last entry ought to be retained for a minimum of 10 years from the day the patient/client turns 18.

RTs working in other practice settings are encouraged to confirm their employer's policies regarding record retention and to refer to legislation that outlines record retention provisions.

Abbreviations

To be understandable, records must use standard abbreviations and be correctly spelled. It is acceptable to use an abbreviation where it is spelled out in full the first time it is used in a notation. Whenever numbers are used, make sure units are included where needed to ensure there is no potential for misinterpretation. When referring to drugs and drug dosages you must always include the units along with any numbers.

Please note…

Abbreviations may vary among different practice environments. It is the Member's responsibility to ensure that the abbreviations being used are accepted in the facility where the record is being used. The CRTO does not provide a list of acceptable abbreviations.

DOCUMENTATION STANDARDS

Complete, accurate, objective and timely documentation is essential to the continuity of care and is the primary mode of communication among health professionals.

There are seven (7) basic standards related to documentation based on the expectation that anyone reading the patient/client's PHR should be able to clearly determine:

1. To **whom** it happened
2. **When** it happened
3. **What** happened
4. **Where** it happened
5. **Why** it happened
6. The **result of what** happened
7. **By whom** it happened

With respect to PHRs, this means that no matter what type or kind of charting is used at a particular facility, anyone reviewing the chart must be able to determine that the above standards have been met. An employer's policies and procedures related to documentation should support the seven standards, as outlined above.

Applying the Documentation Standard

I. To Whom it Happened

1) The standard is that anyone reading the documentation must clearly be able to identify the patient/client who was the recipient of the health care services. Therefore, the PHR must contain Unique Patient/Client Identifiers, such as:

- Patient/client's name and home address;

Please note…

PHRs may become separated; therefore, it's important to ensure that required identifiers (e.g., name, date of birth, OHIP number) are on every page of the PHR and on each piece of document that pertains to that patient (e.g., ventilator flow sheet, overnight oximetry results).

- Patient/client's date of birth and gender;
- Patient/client's health number; and
- ID number.

The patient/client's PHR must also include information as to who is/are the Most Responsible Physician(s) (MRP) (or other health professional(s), if applicable) such as:
The name of the primary care physician and any other health care professional (e.g., Nurse Practitioner); and/or

The name of any admitting, attending and/or referring physician or health care professional.
Reason for referral and/or diagnosis.

II. When it happened

Documentation should be timely and chronological. Common sense suggests the more time that passes between the activity and recording it, the higher the possibility of errors. Documentation that is timely and chronological lends credibility to the accuracy of the record. The date and time must be included in all entries and must be unambiguous. The use of the 24-hour clock is encouraged.

Please note…

Health records must be completed as soon after the event as possible and you are obligated to complete the record before you "finish your shift". Also, do not document before giving patient/client care.

Late entries

If documenting after an amount of time has passed, the entry must clearly be identified as a late entry and should note the time of the event and the time of the late entry as well as the appropriate identification. Documenting activities out of chronological order may suggest that the

Please note…

A Late Entry is an entry into a record that is made more than thirty (30) minutes after the intervention occurred or when the entry is documenting events chronologically out of sequence.

record is not accurate, and for that reason is not ideal. If using paper based PHRs, never leave blank lines for someone else to insert notes. If there are blanks in your record, remember to put a single line through the area to ensure there is not opportunity for the original record to be altered. Also, inserted text or text that extends beyond the recognized writing/recording area may also suggest that the notations were made as an afterthought or to conceal activities.

III. What Happened

Clinically Relevant History

An essential component of effective documentation is a comprehensive summary of the patient/client's clinical history. This should include such information as:

- date and time for each patient/client contact;
- information about every patient/client visit and examination, assessment, intervention, diagnostic procedure performed by the Member;
- information about every clinical finding and assessment made by the Member (e.g. ABG results);
- information about all advice and instruction given by the Member to the patient/client and/or family Member, advocate or caregiver by any method (e.g. in person, telephone, email);
- information about every referral of the patient/client by the Member to another health professional ;
- a financial record if the patient/client if charged a fee;
- information about a procedure or plan of care that was commenced but not completed, including the reasons for non-completion and the original of any written consent; and/or
- any reason a patient/client provides for canceling an appointment, if applicable.

Documenting about Consent

Generally, there are three (3) situations that commonly arise regarding consent and documentation:

1. **Patient/client has provided their consent** to whoever proposed the treatment plan (usually the most responsible physician) and is someone other than the RT. This is commonly referred to as Third Party Consent. The patient/client appears to understand and agree to the plan. In this situation, the RT is not required to document consent, although in some circumstances it may be appropriate to do so. Typically, the higher risk associated with an intervention, the more likely an RT would document the consent.

Third-Party Consent

The *Health Care Consent Act* 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.

For example…

A patient/client consents to a treatment plan that includes intubation and ventilation, if required. However, a family member feels that this course of action is futile and potentially harmful. The patient/client then goes into respiratory failure and the RT intubates them. In this scenario, it is likely important for the RT to document the conversation they had with the patient regarding their previous consent to the procedure.

2. **It is unclear** **whether the patient has provided consent** and the RT is the one performing the procedure. In this situation, the RT is accountable for ensuring that third-party consent has been obtained. If the RT has any doubt whether informed consent has been obtained, it is their professional obligation to obtain it and to document accordingly.

For example…

A patient/client shows up with a requisition for a cardiac stress test in a business suit and seems to have no idea what the test entails. In this scenario, the RT can assume that third-party consent has not been obtained and should provide the necessary information in order to obtain informed consent.

Please note…

When employer policy requires **written consent** for a given intervention (e.g., Pulmonary Function Test), the RT must ensure that there is a signed consent prior to the intervention being initiated.

For more information please see the CRTO Responsibilities Under Consent Legislation (crto.on.ca) ~~***Responsibilities Under Consent Legislation***~~ PPG.

3. In any case where **treatment is given without obtaining consent**, RTs should document their opinions with respect to the patient/client's capacity, as well as all actions taken.

> **For example…**
>
> A patient/client arrives in Emergency obtunded and requiring intubation. They are unable to consent to the procedure; however, delaying this procedure will conceivably result in harm to the patient/client. In this scenario, it is permissible under the *HCCA* to provide the necessary treatment, but the RT should still document their opinions with respect to capacity and all actions taken to obtain consent from a substitute decision maker, if available.

Documenting Patient/Client's Decision to Not Accept a Plan of Treatment/ Intervention

Patients/clients have the right to refuse or withdraw their consent to treatment at any time – provided they are deemed to be capable of giving or withholding consent [see Responsibilities under Consent Legislation PPG]. If a patient/client chooses not to accept a proposed intervention, document the:

- date and time;
- a description of the proposed intervention and the reasons given for providing it:
- reason(s) given by the patient/client;
- information that may have been given for the proposed intervention and the possible outcomes of patient/client not receiving the proposed treatment;
- individuals that were informed about the patient's decision (e.g., prescriber); and recommendations for alternatives, if any.

~~If there is an immediate risk to the patient/client as a result of not receiving the intervention, the prescriber should be notified immediately but the patient/client's decision must also be adhered to and supported~~.

Reporting Adverse Events and Critical Incidents

Adverse events are all unintended injuries or complications that occur during the provision of health care services. Critical incidents are adverse events so severe that they result in the actual or potential loss of life, limb or physical function.

A patient safety or adverse event report ~~incident report is generally an internal document that does not become part of a patient health record. However, it~~ is a record subject to all of the standards of documentation. If you complete an incident report, it's important to remember that information about the incident should also be included in the patient/client's chart.

~~Please note…~~

~~The CRTO's Standard 7 - CRTO Standards of Practice Standards of Practice states that RTs are expected to:~~

- ~~*Report and document all adverse events/near misses and intervening in situations where the safety or wellbeing of the patient/client is unnecessarily at risk.*~~

Cardiac arrests

Most hospitals have specific protocols and procedures for documenting cardiac and respiratory arrests. It is the RT's responsibility to accurately document their activities at these events (e.g., medication administered, defibrillation attempts, endotracheal intubation, etc.). The date, time and outcome of all interventions must be recorded.

Please note…

When signing a cardiac arrest record, it is important to understand that you are attesting to the accuracy of that record. If the arrest record needs to be modified to reflect your role at the arrest, you should ensure that the record is amended in an appropriate manner.

End of Life Documentation

As part of the health care team (and in collaboration with patients/clients and their families), RTs are often involved in some aspect of end-of-life care (e.g., answering family member's questions about what to expect when life support is withdrawn). When a patient/client is going through the process of withdrawing care, clear and accurate documentation is essential. Unfortunately, research has demonstrated that this often is not the case. For example, a ~~2004 study published in the *American Journal of Critical Care*~~ 2011 study published in the BMC Palliative Care Journal found a lack of a systematic approach to the recording of discussions with patients or caregivers about these kinds of issues~~.90 per cent of charts reviewed did not contain any documentation as to whether the patient/client was intubated or extubated at the time of withdrawal.~~

Some aspects that RTs should consider when documenting their involvement in end-of-life care are as follows:

- The support provided to the family in preparation for and during withdrawal of care;
- Any involvement in end-of-life discussion;
- Supportive care provided to the patient/client during withdrawal; and
- Any advance directives or expressed wishes of the patient/client.

Please note…

RTs are required to document according to the same professional standards, whether they are treating an in-patient or out-patient. Whether you are taking an ABG in your hospital's ICU or in your hospital's outpatient PFT clinic, all of the standards for documentation must be met.

Practicing in the community

RTs work in a wide variety of practice settings (e.g., doctor's offices, dental offices, patient education clinics). Regardless of the practice setting, all RTs are accountable for ensuring that all patient/client contacts are documented according to the required professional standards.

For example…

An RT is providing to care to an individual who is in the final stage of their life and is required to take the patient/client off the ventilator and remove their ETT. In this situation, the RT's documentation should include not only these actions, but also the conversation they had with the family prior to, during and after the patient/client was taken off life support.

IV. Where it happened

The record should reference where the patient /client received the intervention unless the location is "normal" for that patient/client. For example, if a treatment was administered in a patient recreation area, or if advice was given to a patient/client over the telephone, the record should indicate this.

Point of Care Testing

Record keeping for point-of-care testing should be treated in a way consistent with the legislation and/or this guideline. Demographic information, date, time and identity and the credentials of the person performing the procedure must be documented and included directly on the test results. Results obtained from the point of care testing should be clearly distinguishable in the health record from those obtained from other sources. Records of quality control results and proficiency testing performance should be maintained for each device.

CRTO Members are encouraged to seek clarification from their employers regarding any requirements when using thermal paper for printing test results (for example – bedside spirometers, oximeters, and other diagnostic equipment). Thermal paper degrades over time and has a relatively short shelf life. Many facilities are now stipulating that any test results printed on thermal paper should be photocopied to ensure the record is viable for the length of time it must be kept, according to legislation.

Patient/Client Transports

Documentation related to a patient/client transport should include the particulars of any interventions and/or monitoring performed during the transport and the details of the transfer of care at the end of the transport. The type of transport should also be documented (e.g., intrahospital, interhospital, air, land).

Telephone Practice

The principles and standards related to documentation of telephone practice is the same those for face-to-face practice. The following elements should be documented:

- time and date of the contact;
- location of the caller (if applicable);
- name of the patient/client and their date of birth (DOB);
- name of caller and relationship to the patient/client, and whether the patient/client has consented to the call/email;
- reason for the call;
- information given by the patient/client or caller;
- symptoms as described by the patient/client or caller;
- advice or information given;
- any follow-up required; and
- signature and designation.

Consider using a log book for this purpose and advocating with your employer to develop standards around telephone and email practice.

V. Why it happened

The reason or purpose of the intervention should be included in your documentation. Is the intervention a routine visit; as a result of diagnostic tests; to perform diagnostic testing; as a result of an improvement or deterioration in status; or as a result of a medical directive or an RT protocol? Why did you do what you did? If you're administering a plan of treatment, it would be appropriate to document why the plan of treatment is being initiated the first time and then only make note of "why" if there's a specific reason to.

Objective Documentation

Objective documentation consists of unbiased observations and witnessed signs that a patient/client displays, as well as symptoms that have been directly stated by the patient/client. Information documented in the PHR should be a factual representation of what actually occurred (objective), as opposed to the RT's interpretations of the events (subjective). Documenting subjective comments can be harmful to both the patient/client's well-being (can impede effective communication) and to the RT's professional reputation. Below are some examples of objective and subjective statements.

Table 1: Examples of Objective vs. Subjective Documentation

Objective	Subjective
"the patient was crying"	"the patient was sad"
"the patient complained of SOBOE and was dyspneic with movement"	"the patient appeared uncomfortable"
"the treatment was not performed because…" list the facts	"this treatment was not in the best interest of the patient"
"I informed Dr. Smith by telephone of the changes to the patient's status as charted in the flow sheet"	"the doctor is aware"

Please note…

Patients/Clients and/or their family members have a legal right to access medical records. Therefore, any personal judgements and opinions that an RT might have should not be part of a PHR.

VI. The result of what happened

It's essential that the outcome of every intervention is captured in the PHR. This gives the entire health care team the ability to know what was done and whether the intended therapy goals were met. This information is invaluable in guiding future treatment decisions, and should include such information as:

- the result of the intervention;
- the patient/client's response to the intervention;
- whether the treatment objectives were met;
- proposed plan as a result of the intervention; and
- the RT's plan for follow up, if applicable.

For example…

An RT has been asked to initiate BiPAP on a patient/client who has elevated $PaCO_2$ levels and is nearing the end of a terminal illness. Both the patient and the RT agree to the treatment plan, although the RT feels the benefits of the therapy will be limited. When documenting, it is important to include not only the intervention itself, but also the treatment goal(s) and plan (e.g., how long the patient/client will remain on BiPAP; when the treatment plan will be reassessed; how and when the RT plans to follow up on the patient/client's progress).

VII. By whom it happened

Signatures

Anyone reading the documentation must be able to clearly identify the individual performing the activity or making the recording, while making sure there is a unique identifier for that person (e.g., signature). This means that a CRTO Member should provide a signature at the end of the entry with at least a first initial, last name and professional designation (abbreviation is acceptable).

A signature (and/or initials) certifies the information provided and gives assurance that the record of activity, assessment, behavior or procedure is accurate and complete. CRTO Members must not give permission to anyone else to sign their name to a document under any circumstances. Members also must not sign someone else's name to a document.

Please note…

If using a paper-based **signature record,** initials and professional designation are sufficient. If a signature record is not used, a printed name should be included if a signature is not easily legible.

Co-signing Documentation when Supervising Others

When an RRT is supervising another individual [usually a Student Respiratory Therapist (SRT); however, it may also be an RRT who has Terms, Conditions and Limitations (TCLs) on their certificate of registration], it is essential that the documentation accurately reflect the following:

1. What degree of supervision was provided; and
2. Who performed each task and who provided supervision.

Direct Supervision occurs when the SRT (or Member with TCLs) performs a controlled act with the RRT observing and overseeing the task. In these cases, the student (or Member with TCLs) must document in the patient/client's PHR that they have performed the procedure(s) under

"direct supervision". The supervising RRT must then co-sign the entry in the patient/client PHR stating that the documented activity took place "under direct supervision". An example of direct supervision would be a supervising RRT, physically observing and guiding the performance of arterial blood gas sample being drawn by an SRT.

Please note…

The CRTO recognizes that common RT flow-sheets used in critical care areas (such as ICU and NICU) may not provide enough space for Members to explicitly state that the activity was done under direct supervision. We suggest that you may want to reference somewhere in the patient/client health record that where two (2) initials are present, this indicates that direct supervision took place.

General Supervision involves those situations where a determination has been made that the SRT (or Member with TCLs) can perform a given controlled act independently. Where activities or procedures are being done under general supervision, the supervising RRT must not co-sign the student's documentation. The reason for this is that co-signing means the RRT is attesting to the accuracy of the documentation. If they did not witness the task(s) performed, they have no absolute way of knowing if the documentation is correct. Only the person who performed the activity/procedure or has the patient contact should document and sign the entry.

Please note…

General (indirect) Supervision requires that the supervising RRT is ready and available to be "*personally present*" within 10 minutes if assistance is required.

(CRTO *Supervision* Policy)

For example…

An RT student in their final clinical rotation is performing an arterial blood gas under "general" supervision (i.e. the supervising RT is not physically present and observing the activity). Since the activity is being done under "general" supervision in this situation (not under direct supervision), the student must sign their own documentation and the RRT should not co-sign.

Interdisciplinary Documentation

RTs very often work as part of a multidisciplinary team that collectively provides diverse and overlapping health care services. As with any well-functioning group, effective communication within and outside of the team is vital. In order to facilitate this communication, many health care facilities have moved towards more integrated, interdisciplinary documentation records.

ADDITIONAL CONSIDERATIONS

Please note…

It is important that you DO NOT document for someone else. There may be instances when it becomes necessary to document observations on care provided by others, (e.g., a family member witnesses a patient/client fall). It ~~has to~~ must be clear who had the first-hand knowledge of the event, who performed the activity/intervention and who recorded the activity.

Documenting a Disagreement with an Order or Plan of Treatment

If an RT does not believe that a particular order or a proposed plan of treatment is in the patient/client's best interest, it is their professional responsibility not to proceed with the intervention. In addition, the RT is expected to:

- remain objective and not involve the patient/client in the disagreement, if at all possible;
- contact the prescriber to discuss the rationale for the difference of opinion, and any suggested alternative plans; and
- provide comprehensive documentation appropriately, which includes:
    - the rationale for their refusal to provide treatment;
    - when notice was provided to the prescriber and details about discussion with prescriber, if applicable; and
    - suggested alternatives, if applicable.

Withdrawal of Care/Services Due to Abuse or Violence

Withdrawing or withholding care/services from a patient is not common and only used as a last resort in a strategic plan for managing abuse/violence. However, it may become necessary if there is a significant threat or risk of serious injury to a Member of the staff, fellow patient or a visitor. Balancing the patient's interest in receiving care against the risk of harm to others is particularly difficult in situations where the care is necessary or time-sensitive. Where it becomes necessary to withdraw or withhold care/services, documentation should include the following:

- the date and time;
- the rationale for withdrawal of care/services;
- the circumstances leading up to and including the withdrawal of care/service including the information given to the patient of the action that will be taken if the behavior continues;
- how and when information relating to the withdrawal of care/services was provided to the patient/client (e.g., verbally, in writing);
- the process used by you (i.e., employer established guidelines for managing violent or abusive behavior by patients) including all attempted efforts to resolve the situation;
- the potential consequences of withdrawing care;
- the expected standards/behaviors that must be adopted by the patient/client in order to have care/services resume in the future, if applicable;
- an alternate provider of care/service or the efforts made to refer the patient to alternate providers (if appropriate); and
- who you have notified of the situation (patient/client, physician, charge nurse, police, security, etc.)

For more information and scenarios regarding the ethics of withdrawing or withholding respiratory therapy care/services, please refer to the CRTO document ~~A Committment to Ethical Practice~~

A Commitment to Ethical Practice.

GLOSSARY

Agents (of the Health Information Custodians) – is defined in the *HCCA* in relation to a health information custodian, as "…*a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian*…"

CRTO Member – is a respiratory therapist who is registered with the CRTO; including Graduate Respiratory Therapists (GRT), Practical (Limited) Respiratory Therapists (PRT) and Registered Respiratory Therapists (RRT).

Charting by Exception (CBE) –a charting system used in patient/client health records. CBE requires a detailed plan of care of care map, and includes flowsheets, graphic records and progress notes that may take the format of SOAP/SOAPIE(R) (Subjective, Objective Data, Assessment, Plan, Intervention, Evaluation, and Revision).

Focus Charting System – a charting system which includes flow-sheets, checklists and progress notes that take the format of DARP (Data, Action/Analysis, Response, and Plan).

Health Information Custodian (HIC) - defined in the *HCCA* as *"…a person or organization described in one of the following paragraphs who has custody or control of personal health information…".*

Medical Directive – is a medical order for a range of patient/clients who meet certain conditions. The medical directive is the order and should therefore meet the criteria for a valid medical order.

Narrative Charting – is when data is recorded as progress notes, supplemented with plan of care flow sheets.

Personal Health Records (PHR) -is the record kept by HICs who provide health care and may be in either a paper-based or computerized format.

Primary Care – including, but not limited, to Family Health Teams, Community Health Centres, various agencies, such as the Canadian Mental Health Agency.

Problem-oriented Charting (POHR) - a charting system which includes a plan of care, problem list and progress notes/discharge plans which take the format of "SOAP/SOAPIE" (Subjective data, Objective data, Assessment data, Plan, Intervention and Evaluation).

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AGENDA ITEM # 4.7 **September 24, 2021**

From:	*Kelly Arndt RRT, Quality Practice Coordinator*
Topic:	*Draft Revised Delegation of Controlled Acts Professional Practice Guideline (PPG)*
Purpose:	*For Decision*
Strategic Focus:	*Protecting patient safety by ensuring Respiratory Therapists understand their professional and legislative responsibilities surrounding the delegation of controlled acts.*
Attachment(s):	Appendix A - Current Delegation of Controlled Acts PPG Appendix B – Revised Delegation of Controlled Acts PPG

PUBLIC INTEREST RATIONALE:

Ensuring that Respiratory Therapists understand their professional and legislative requirements and responsibilities with respect to delegation.

ISSUE:

Previously revised in February 2013, the Delegation PPG has been revised to reflect current delegation practice, legislative and professional responsibilities.

BACKGROUND:

The topic of Delegation is one that can be misunderstood. This PPG has been condensed, with updated and simplified content to facilitate understanding and clear direction in delegation and accepting delegation.

ANALYSIS:

Summary of Changes
The Delegation PPG has been revised to include further examples, the role of delegation in healthcare, a condensed overview of delegation among RRT's, GRT's and SRT's. The examples of the application of energy have been condensed, as this content is now in the revised Interpretation of Authorized Acts PPG. All gender pronouns have been neutralized and references have been updated. A jurisdictional and regulatory scan was conducted to confirm the content of the document is current and aligned with all relevant legislation and regulations.

RECOMMENDATION:

It is recommended that the CRTO Council review and approve the revised Delegation of Controlled Acts PPG for circulation for feedback from members and stakeholders.

NEXT STEPS:

If the motion is approved, the PPG will be circulated for public consultation and review. A final draft will be presented at the December 2021 Council meeting.

AGENDA ITEM # 4.7

Motion Title:	*Draft Revised Delegation of Controlled Acts Professional Practice Guideline*
Date of Meeting:	*September 24, 2021*

It is moved by _____ and seconded by _____ that:

Council approves the *Draft Revised Delegation of Controlled Acts Professional Practice Guideline* for circulation and feedback. (A copy is attached as Appendix B to this motion within the materials of this meeting)

Current Delegation of Controlled Acts Professional Practice Guideline

College of Respiratory Therapists of Ontario

Professional Practice Guideline

CRTO publications contain practice parameters and standards which should be considered by all Ontario Respiratory Therapists in the care of their 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.

> It is important to note that employers may have policies related to an RT's ability to accept delegation to dispense medications. 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.

February 2013

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INTRODUCTION

The *Regulated Health Professions Act, 1991* (RHPA) identifies thirteen **controlled acts** that pose significant risk of harm to the public of Ontario. .

These acts may only be performed by regulated health professionals who are authorized by their profession specific Acts to do so[1]

If a procedure involves controlled acts that are not authorized to Respiratory Therapists [2] then the authority to perform those controlled acts can only come from **delegation** from another authorized regulated health care professional OR an **exception** under the RHPA.

This Professional Practice Guideline (PPG) provides information regarding the standards of practice related to the delegation of controlled acts.

Delegation - what you need to know.

- Delegation is the transfer of legal authority to perform a controlled act to a person not authorized to perform that controlled act.
- Delegation often refers to the transfer of authority to perform "procedures"

[1] For a complete list of regulated health care professionals , and link to their respective websites, please visit the Federation of Health Regulatory Colleges of Ontario (FHRCO) at: http://ipc.fhrco.org/

[2] See PPG Interpretation of Authorized Acts Table 1 for a comparison of the controlled acts (RHPA), authorized acts (RTA) and acts that Respiratory Therapists may accept delegation for.

involving one or more controlled acts.

- Procedures and/or activities that do not involve controlled acts, do not require delegation, however they may still require orders depending on the practice setting.
- Delegation is a PROCESS that is procedure specific and may also be specific to:

    - an individual patient/client;
    - a specific patient/client population;
    - a specific situation;
    - a specific health care provider, or;
    - groups of patient/client populations or health care providers.

- While it is permissible to delegate the performance of a procedure involving a controlled act to a health care provider (regulated or non-regulated) who is not authorized to perform that controlled act, it is not permissible to delegate the ordering of that procedure involving a controlled act to someone else.

- It is the position of the CRTO that there is no provision in the RHPA to allow a Physician or any other regulated health care professional to "delegate" the ordering of a procedure involving a controlled act to another health care provider (see the CRTO *Medical Directives and the Ordering of Controlled Acts* Position Statement).

Authorized Acts

The controlled acts authorized to Respiratory Therapists in the *Respiratory Therapy Act, 1991* (RTA) are:

In the course of engaging in the practice of respiratory therapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Performing a prescribed procedure below the dermis.
2. Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx.
3. Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx.
4. Administering a substance by injection or inhalation.
5. Administering a prescribed[3] substance by inhalation.

Did you know...

The RTA states that the legislated scope of practice of RTs 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.

RTs may only accept delegation for certain controlled acts while acting within their scope of practice. For example an RT may accept delegation to perform allergy testing but not setting or casting a fracture of a bone or a dislocation of a joint. Please refer to the PPG Interpretation of Authorized Acts Table 1 for more information.

The RTA requires an order for all controlled acts authorized to Respiratory Therapists (regardless of practice setting) except* for:

- suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx; and
- Administering a prescribed substance by inhalation[4].

*Please not that, depending on the practice setting, other legislation may require an order even for these acts (e.g., the *Public Hospitals Act*).

If you have terms, conditions or limitations prohibiting you from performing any respiratory therapy procedures that involve controlled acts, you cannot accept delegation for those procedures. (See CRTO Policies: Graduate Certificate of Registration; Supervision Policy; Inactive Certificate of Registration Policy)

[3] "prescribed" means listed in the Prescribed Substances Regulation (see Part VII.1) i.e., the independent administration of therapeutic oxygen by an RRT.

[4] Refer to CRTO Communiqué Dec 21, 2012 regarding the new Prescribed Substances Regulation (November 2012) http://www.crto.on.ca/pdf/Misc/Regulations_Update_Dec_2012.pdf

Did you know...

Terms, Conditions and Limitations (TCLs)

- If you decide to suction a patient and there is a limitation on your certificate preventing you from suctioning, then you cannot go ahead and accept delegation to suction.

- Student Respiratory Therapists who *were* permitted to perform advanced prescribed procedures below the dermis (under an exemption in the *RHPA*), are *no longer* permitted to perform advanced prescribed procedures once they become GRTs. GRTs are not permitted to accept delegation for these controlled acts in order to proceed*. (See *Registration and Use of Title* PPG and *Certification Programs for Advanced Prescribed Procedures below the Dermis* PPG)

***Please note...**GRTs are not permitted to delegate or accept delegation for any controlled act.

Did you know...

Authorizing Mechanisms - Orders *and* Delegation

- RTs do not require delegation to perform authorized acts 1, 2 and 4 – but still require an order or medical directive to proceed. (se *Interpretation of Authorized Acts* PPG and *Orders for Medical Care* PPG)

- RTs performing procedures involving delegated controlled acts (e.g., allergy testing) also require a valid order or medical directive to proceed. (see *Orders for Medical Care* PPG, *Medical Directives and the Ordering of Controlled Acts* *Position Statement*)

- The Federation of Health Regulatory Colleges of Ontario (FHRCO) has published interprofessional guides, tools and templates to assist regulated health care professionals to develop processes for delegation and the use of medical directives. The aim of these tools is to meet all the regulated professional standards of practice (see FHRCO's Guide and IPC **eTool)**.

- Procedures and activities that do not involve controlled acts and that fall within the public domain do not require delegation may require still require an order.

WHAT IS NOT DELEGATION?

An assignment of responsibility and/or duties is not delegation. Even if you are "assigned" to care for patient/client(s) by your supervisor (e.g., a physician, midwife, nurse practitioner or dentist) you would require proper delegation (and orders) to perform any specific procedures involving controlled acts that are not authorized to you. Another regulated health professional asking or instructing you perform a controlled act in the moment, does not constitute the process of “delegation" or the transfer of their authority to you.

“Assisting” a regulated health professional to perform controlled acts does not mean that his or her authority to perform the controlled act has been transferred to you. In this case you are only assisting with the procedure and do not require delegation.

Teaching someone to perform a controlled act (e.g., a regulated; non-regulated health care provider, or other caregiver) may not be enough. Delegation is a process. For more information regarding the standards of practice of teaching versus delegation and a variety of common practice scenarios, please refer to the PPG *Responsibilities of Members as Educators*.

WHEN IS DELEGATION NOT REQUIRED?

If the procedure is not a controlled act, it is in the **public domain** and delegation is not required. In this case, you may perform the procedure provided you have the **competency** to perform it. Depending on your practice setting you may require an order to proceed.

Did you know...

Public Domain

- Administering an oral medication is not a controlled act and does not require delegation; however administering an oral medication does require an order or a prescription in most practice settings.
- Performing spirometry is not a controlled act and does not require delegation, but does require an order in a hospital or pulmonary function testing (PFT) laboratory.
- Performing cardioversion or allergy testing are controlled acts not authorized to RTs that each require a process for delegation AND an order (or medical directive).

RHPA Exceptions

If a procedure ~~i~~nvolves a controlled act and you do not have the authority to perform it (i.e. the procedure is not one authorized to Respiratory Therapists), you may perform the controlled act in one of the following exceptions allowed by the RHPA *[as listed and numbered in the RHPA]:*

Exception #1:
Giving first aid or temporary assistance in an emergency.

You may perform a controlled act in giving first aid provided you have the competency (knowledge, skills and judgment) to perform the procedure.

If a Respiratory Therapist faces an emergency situation, he or she should not let fear of prosecution for performing a controlled act hinder his or her response. The College also encourages Respiratory Therapists and their employers who face emergencies on a regular basis to proactively develop policies and procedures, guidelines, processes for delegation and medical directives to help guide their response. These documents may also serve to provide evidence of competency training and ongoing quality assurance to support the practice of Respiratory Therapists in emergent situations.

Did you know...

The application of energy is a controlled act not authorized to RTs?

Examples of Applying Energy

- An Respiratory Therapist who is anAnesthesia Assistant) requires delegation and a valid order (or medical directive) for the application of energy to assess neuromuscular blockade during general anesthesia.
- Many acute care organizations (hospitals) have implemented processes to delegate the application of energy (e.g., defibrillation) and the use medical directives to authorize and enable RTs as first-responders to defibrillate in a code blue or code pink situation. Many hospitals are also choosing to use automated external defibrillators (AEDs). Respiratory Therapists who practice in hospital settings where codes are expected should ensure they are competent and maintain their ongoing competency to apply energy to the expected standards of their profession, and their employer's, even when using AEDs. RTs practicing in these scenarios, are acting as regulated health care professionals. The process for delegation may include education and training for example as an organizational requirement for RTs to maintain their BCLS, PALS and/or ACLS. Please refer to the CRTO's *Use of automated external Defibrillators (AEDs) by Respiratory therapists* Position Statement.
- The use of ultrasound to guide the insertion of arterial (e.g., in neonates) and venous catheters (e.g., internal jugular) is becoming a more common practice for Respiratory Therapists. Under section 7 of the Controlled Acts Regulation 107/96, Members may be exempt from requiring delegation to perform diagnostic ultrasound e.g., to insert an arterial catheter or diagnose a chest pneumothorax in neonates; in certain practice settings (i.e., public hospital). Members would need to ensure their competency to apply ultrasound (see *Scope of Practice and Maintenance of Competency* Position Statement) and also requires an order (or medical directive) to proceed.

Exception #2:

Fulfilling the requirements to become a member of a health profession and the controlled act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession.

Student Respiratory Therapists do not require delegation to perform controlled acts provided they are enrolled in a CRTO approved program to become Respiratory Therapists AND the controlled acts are within the scope of practice AND a Member of the College is supervising or directing them.

Exception #3:

Treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;

If you are performing a controlled act in treating a person by prayer or spiritual means in accordance with the principles of your religion you do not need to have the act delegated to you.

Exception #4:

Treating a member of the person's household and the act is controlled act 1, 5 or 6 *(as numbered in the RHPA);* and, the acts that may be performed when treating a member of your household are:

a) Communicating to the member of your household, or his or her personal representative, a diagnosis identifying a disease or disorder as the cause of symptoms of the member of your household, in circumstances in which it is reasonably foreseeable that the member of your household, or his or her personal representative, will rely on the diagnosis.

b) Administering a substance by injection or inhalation;

c) Putting an instrument, hand or finger;

- beyond the external ear canal,
- beyond the point in the nasal passages where they normally narrow,
- beyond the larynx,
- beyond the opening of the urethra,
- beyond the labia majora,
- beyond the anal verge, or
- into an artificial opening into the body.

Exception #5:
Assisting a person with his or her routine activities of living and the act is controlled act 5 or 6 *(as numbered in the RHPA).* The acts that may be performed when assisting an individual with his or her activities of daily living are:

a) Administering a substance by injection or inhalation,
b) Putting an instrument, hand or finger;
beyond the external ear canal,

- beyond the point in the nasal passages where they normally narrow,
- beyond the larynx,
- beyond the opening of the urethra,
- beyond the labia majora,
- beyond the anal verge, or
- into an artificial opening into the body.

These exceptions mean that a person is not in contravention of the RHPA if he or she performs the controlled acts under the exceptions listed above.
Exemptions

A Few Points to Consider...

As a member of the College, you may be held to the expected standards of practice of the College and the profession in your performance of a procedure, even if it is performed under the exemptions allowed by the RHPA.

Delegation is not required/necessary when a regulated health professional already has the authority to perform the authorized controlled act.

- E.g., It is not necessary to delegate oxygen therapy administration to a registered Physiotherapist in a hospital setting. Physiotherapists are authorized to perform the controlled act administering a substance by inhalation in the *Physiotherapy Act*.
- E.g., it is unnecessary for RTs to receive delegation from a physician to intubate, because intubation is a controlled act authorized to CRTO Members under the Respiratory Therapy Act. An order (or medical directive) is still required to perform intubation, delegation is not.

WHEN IS DELEGATION REQUIRED?
In all practice scenarios not covered by the "public domain" or included in the RHPA

"exceptions", the authority to perform a controlled act other than the acts authorized to Respiratory Therapists MUST come from delegation from another competent, regulated health care professional who has the authority to perform the controlled act and who is not prohibited from delegating the procedure by his/her specific College.

CAN I ACCEPT DELEGATION OF PROCEDURES?

Yes, you may accept delegation of controlled acts not authorized to CRTO Members under the RTA when all of the following conditions are met:

1. You reasonably believe that the **delegator** has the authority and competence to perform and to delegate the controlled act. In other words, you have no reason to believe that the delegator is not permitted to delegate the controlled act; and

2. You have the authority to perform the controlled act safely, effectively, competently and ethically. In other words, you have no terms, conditions or limitations on your certificate of registration which may prohibit you from performing the delegated controlled act; and

Please note that Graduate Respiratory Therapists (GRT) are prevented by the terms, conditions and limitations on their certificate of registration from accepting delegation for any controlled act. (e.g communicating a diagnosis). Supervision issue…

3. You have the **competency** to perform the controlled act. In other words, your competency to perform the delegated controlled act has been confirmed either directly or indirectly by a regulated health care professional who is also competent and has the authority to perform the procedure; and

4. You have determined that receiving delegation of the controlled act is appropriate giving due consideration to:

a) the best interest of the patient/client
b) the known risks and benefits of performing the procedure for the patient/client(s),
c) the predictability of the outcomes of performing the procedure,
d) the patient/client's wishes,
e) the safeguards and resources available in the situation; and
f) other elements specific to the situation.

When making the decision to accept delegation to perform a controlled act

that is not authorized to you under the RTA, you are reminded that authority alone is not reason enough to perform the procedure. You must have the competency to perform the delegated procedure and most importantly, performing the procedure must be in the patient/client's best interests.

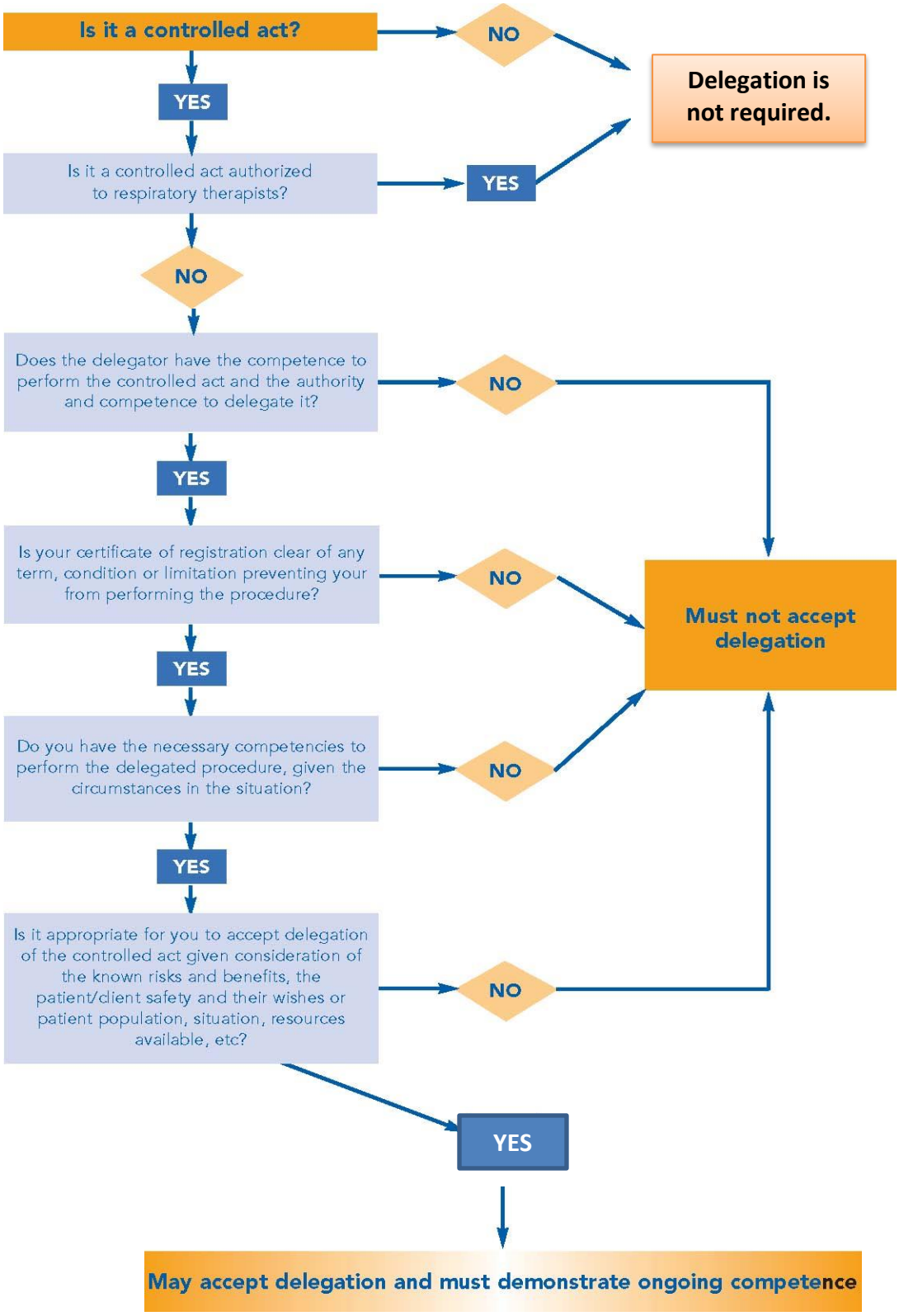
WHO CAN DELEGATE TO ME?

As specified in the RHPA, a Regulated Health Professional with the authority to perform a controlled act is the only person who may delegate a controlled act. (e.g., delegation cannot be received from a committee). It is possible for more than one profession to have the authority to perform and delegate the same controlled act. For more information regarding the scopes of practice of other regulated health care professionals and their controlled acts visit the FHRCO's website.

- Scopes of Practice
- Scopes Chart
- Controlled Acts
- Controlled Acts Chart

You must not accept delegation from individuals who themselves have received delegation to perform a controlled act procedure. For example, you cannot accept delegation as the authority to perform the controlled act of administering a form of energy (defibrillation) from a unregulated health care provider e.g., a Physician's Assistant (PA) who has received delegation from a physician to perform the procedure. In this scenario, the PA, does not have the authority to delegate a controlled under the RHPA. Further, delegated controlled acts may not be delegated over again to another person. This amounts to the concept of "sub-delegation" which is not permitted.

Accepting Delegation Decision Flowchart



WHAT ARE MY RESPONSIBILITIES WHEN I ACCEPT DELEGATION?

You are responsible for the performance of the procedure to the standard of the profession of the delegator or the generally accepted standard of practice of health care practitioners providing similar care. In other words, you must have the requisite competency (knowledge, skills and judgment) to perform the procedure before you accept delegation.

You should also maintain proper documentation of your actions by keeping a record of what activities you accepted delegation and who delegated the activities to you. The preferred method of doing this is to keep records of delegation (and other professional development) in your learning log and Quality Assurance (QA) Portfolio Online for Respiratory Therapists (PORTfolio) . Your competency records regarding delegation should include the following:

- the regulated health care professional (e.g. physician) who has delegated the controlled act;
- the controlled act that have been delegated to you;
- continuing education related to the delegated controlled act; and
- the period of time that the delegation remains in force prior to requiring reconfirmation of ongoing competence in the procedure. (e.g. an organizational requirement that the delegation you receive to perform defibrillation may be time-limited to one year or the expiry date of your ACLS certification , at which time you must once again demonstrate competence in the procedure).

Remember that just because you can accept delegation doesn't necessarily mean that you should accept delegation. CRTO Members must consider whether it is appropriate, safe and ethical and in the best interest of the patients/clients that you are caring for.

Most employers will have policies and procedures regarding delegation detailing their process for giving and receiving delegation. You should check your employer's policies before accepting delegation. Your employer may also have specific requirements regarding documentation when you accept delegation to perform a controlled act procedure. For more information regarding documentation obligations, please see CRTO's Documentation PPG.

DELEGATING RT AUTHORIZED ACTS

CRTO Members may delegate procedures within the controlled acts authorized to Respiratory Therapists, but only when all of the following conditions are met:

1. You have the authority (related to terms, conditions or limitations on your certificate of registration - specifically related to you as an individual or as a holder of a particular class of certificate of registration), and competence (knowledge, skills and judgment) to perform and to delegate the procedure safely, effectively, competently and ethically; and

2. You reasonably believe that the delegatee has acquired, through teaching and clinical supervision of practice, the competence to perform the procedure safely, effectively, competently and ethically; and

3. You have no reason to believe that the delegatee is not permitted to accept the delegation; and

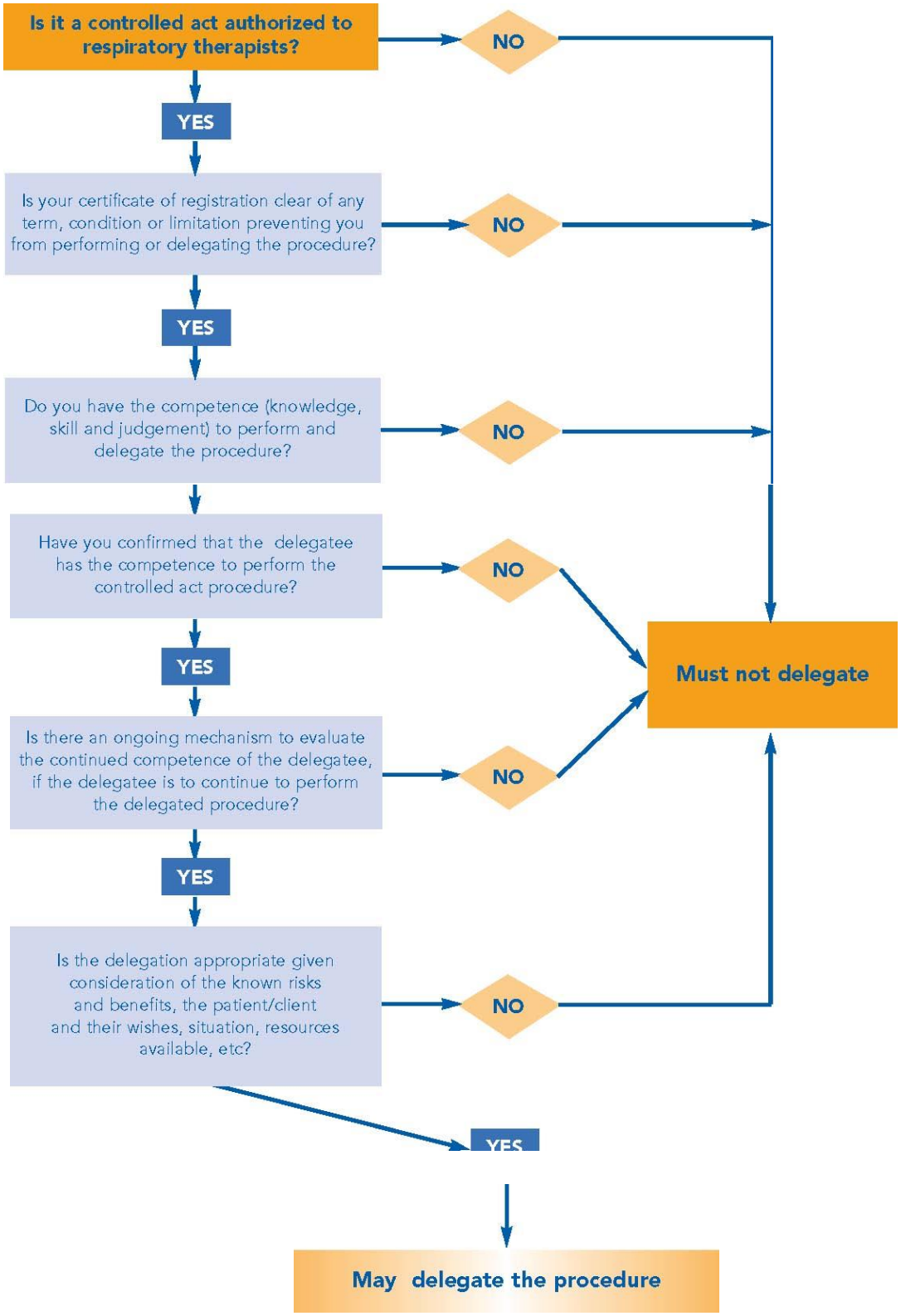
4. You verify, or reasonably believe an evaluation mechanism is in place to verify, the continued competence of the delegatee for performing the procedure; and

5. You have determined that delegation of the procedure is appropriate giving due consideration to:

a) the known risks and benefits of performing the procedure for the patient/client(s);
b) the predictability of the outcomes of performing the procedure;
c) the patient/clients' wishes;
d) the safeguards and resources available in the situation; and
e) other elements specific to the situation.

Please note…Due to the fact that tracheostomy tube changes are now listed as an exemption in the *Controlled Acts* regulation, respiratory therapists (RRT, GRT and PRTs) are no longer permitted to delegate tracheostomy tube changes

Delegation Decision Flowchart



WHAT PROCEDURES CAN I DELEGATE?

CRTO members may delegate any RT authorized act procedures to another regulated or non-regulated health care provider provided they meet their professional responsibilities which are outlined below.

WHAT ARE MY RESPONSIBILITIES WHEN I DELEGATE?

You are responsible for ensuring that a mechanism exists for education, supervision and on-going competence evaluation of the delegatee. You should never assume that the individual has the necessary competencies to perform the controlled act procedure that you are authorizing to them through delegation. You must confirm or validate that they can safely perform the procedure to the same standard that you would perform the procedure.

In practical terms, this confirmation might mean that that you alone are the person performing all of the components of the confirmation of competence (education, supervision, evaluation) or you may be part of a team. You must ensure that you meet the standard of practice of the College and the profession before you delegate a procedure. You are responsible for delegating the procedure and the delegatee is responsible for accepting and performing the procedure.

Assuming responsibility for the delegation does not mean you assume responsibility for the delegatee's performance of an individual procedure. It is your responsibility to ensure that, given consideration to all circumstances, the delegation is appropriate. As with any other intervention you undertake, it is your responsibility to ensure proper documentation of your actions by keeping records of the individuals to whom you delegate and the specifics of the procedures that you delegate. CRTO Members are encouraged to keep records of what and to whom they have delegated in their QA PORTfolio.

Records should include the following:

- description of the procedure being delegated,
- information related to the education that was provided to the delegatee (number of hours, curriculum, any handouts, tests, etc.),
- who provided it (yourself or a team of RRTs for example);
- description of the "certification process", and
- the quality management activities and any particular specifics related to ongoing quality monitoring and evaluation of the delegation.

Your employer may have specific requirements regarding delegation and documentation that you will need to be familiar with prior to delegating.

You are professionally accountable for your decision to delegate a procedure and you must ensure you have satisfied all of the requirements outlined in this practice guideline. The "reasonably believe" concept requires that you act prudently. For example, if your employer has a policy that outlines an evaluation process for assessing the competence of delegatees, that you know in practical terms is not adhered to, it is your obligation not to delegate procedures until the reality matches the policy. It also means that you do not personally have to supervise, teach and evaluate a delegatee but you are responsible to ensure that an appropriate process is in place. If you are reasonably satisfied that a certification program appropriately assesses competence then it would be reasonable to accept that successful completion of the program means that an individual has the requisite competence to perform the procedure.

Making a decision to delegate your authority to perform a controlled act to another individual should not be taken lightly. The ultimate decision to delegate rests with you.

(Please refer to the PPG Responsibilities of Members as Educators for more standards of practice related to teaching and delegation.)

UNDER WHAT CIRCUMSTANCES AM I NOT PERMITTED TO DELEGATE?

You must not delegate a controlled act procedure:

1. That is not authorized to you according to the Respiratory Therapy Act. For example, you cannot delegate a controlled act procedure, which you yourself require delegation from another RHP to perform. This amounts to the concept of "sub-delegation" which is not permitted;

2. To an RHP (including a Respiratory Therapist) who is prevented from performing the procedure due to terms, conditions or limitations on his or her certificate of registration; or

3. To an individual who you do not reasonably believe has the competence to perform the procedure.

Did you know...

CRTO members who hold a General Certificate of Registration may not delegate an RT authorized act to a member with a Graduate certificate of registration, who is prohibited from performing the procedure due to terms, conditions and limitations on their certificate. An RRT may not delegate chest tube insertion to a GRT.

WHAT ARE THE PENALTIES IF I PERFORM A CONTROLLED ACT WITHOUT THE AUTHORITY TO DO SO?

If you or another RHP perform a controlled act when you are not permitted to do so, you may be subject to professional misconduct proceedings. (See Professional Misconduct Regulation provision 1.4).

Glossary

Authority the right to act - usually related to **jurisdiction provided in a statute or to** terms, conditions or limitations imposed on a certificate of registration - individually specified (by a panel) or related to an entire class of certificates of registration (specified by Council or a panel)

Authorized act is a controlled act, or portion of a controlled act, that is authorized within a health profession act for a health professional to perform [there are 4 acts authorized to Respiratory Therapists by the Respiratory Therapy Act, that are created from 3 controlled acts defined in the RHPA]; the controlled acts authorized to Respiratory Therapists are:

1. Performing a prescribed procedure below the dermis;
2. Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx;
3. Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx;
4. Administering a substance by injection or inhalation; and
5. Administering a prescribed substance by inhalation.

Controlled act one of the following 13 acts defined in the RHPA [section 27(2)] when it is performed "with respect to an individual":

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
    i) beyond the external ear canal,
    ii) beyond the point in the nasal passages where they normally narrow,
    iii) beyond the larynx,
    iv) beyond the opening of the urethra,
    v) beyond the labia majora,
    vi) beyond the anal verge, or
    vii) into an artificial opening into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling or compounding a drug as defined in subsection 117 (1) of the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

Competence having the requisite knowledge, skills and judgement to perform the procedure

Delegatee the person receiving the authority to perform a procedure

Delegator the person conferring the authority for another to perform a procedure

Emergency when the patient/client is apparently experiencing severe suffering or is at risk, if the procedure or treatment is not administered promptly, of sustaining serious bodily harm.

Forms of energy the following forms of energy are prescribed in regulation:

1. Electricity for,
    - i) aversive conditioning
    - ii) cardiac pacemaker therapy
    - iii) cardioversion
    - iv) defibrillation
    - v) electrocoagulation
    - vi) electroconvulsive shock therapy
    - vii) electromyography
    - viii) fulguration
    - ix) nerve conduction studies, or
    - x) transcutaneous cardiac pacing
2. Electromagnetism for magnetic resonance imaging
3. Soundwaves for,
    - i) diagnostic ultrasound, or
    - ii) lithotripsy

HPPC Health Professions Procedural Code - RHPA; Schedule 2

Member a member of a regulatory college under the RHPA

Reasonably sensible, rational - often referred to as the reasonable person test - determined by case law - in the case of the College, a panel would determine whether or not an individual, giving consideration to all circumstances, acted in a sensible, rational manner in the matter under discussion

Respiratory Therapist a Member of the CRTO (refers to RRT, GRT, PRT, Inactive Member)

RHP Regulated Health Professional a health care provider who is a member of a College and is regulated by the RHPA (e.g., nurse, physician, dentist, massage therapist, physiotherapist, dietitian, occupational therapist, etc)

RHPA *Regulated Health Professions Act, 1991*

RTA *Respiratory Therapy Act, 1991*

References

College of Nurses of Ontario (2006). *Practice standard: Decisions about procedures and authority.* Retrieved February 7, 2007 from www.cno.org/docs/prac/41071_Decisions.pdf

College of Physicians and Surgeons of Ontario (2004, November). *Policy #4-03: Delegation of controlled acts.* Retrieved February 7, 2007 from www.cpso.on.ca/Policies/delegation.htm

College of Respiratory Therapists of Ontario (2004, April). *Professional practice guideline: Interpretation of authorized acts.* Retrieved February 7, 2007 from www.crto.on.ca/pdf/ppginterpauthoracts.pdf

Federation of Health Regulatory Colleges of Ontario (2007). *An interprofessional guide on the use of orders, directives and delegation for regulated health professions in Ontario.* Retrieved February 7, 2007 from www.medicaldirectives-delegation.com/why/

Legislation

Regulated Health Professions Act, 1991. (see s27) www.e-laws.gov.on.ca/DBLaws/Statutes/English/91r18_e.htm

Respiratory Therapy Act, 1991.(see s4) www.e-laws.gov.on.ca/DBLaws/Statutes/English/91r39_e.htm

1999: Revised February 2003; Revised January 2004; Revised September 2005; Revised February 2007; Revised February 2013.

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

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Toronto, Ontario M5G 1Z8
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www.crto.on.ca

Draft Delegation of Controlled Acts Professional Practice Guideline to replace the current Delegation of Controlled Acts Professional Practice Guideline

College of Respiratory Therapists of Ontario

Professional Practice Guideline

CRTO publications contain practice parameters and standards which should be considered by all Ontario Respiratory Therapists in the care of their 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.

> It is important to note that employers may have policies related to an RT's ability to accept delegation to dispense medications. 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.

-February 2013

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.

Table of Contents (update format)

INTRODUCTION

The *Regulated Health Professions Act, 1991* (RHPA) identifies fourteen ~~thirteen~~ **controlled acts** that pose significant risk of harm to the public of Ontario.

These acts may only be performed by regulated health professionals who are authorized by their profession specific Acts to do so.[1]

There are several authorizing mechanisms, such as an order, initiation, directive, or delegation, as specified in legislation, whereby Respiratory Therapists obtain the authority to perform a procedure.

If a procedure involves controlled acts that are **not** authorized to Respiratory Therapists, [2] then the authority to perform those controlled acts can only come from two places:

- **delegation** from another authorized regulated health care professional

OR

- an **exception** under the RHPA. For a comparison of the controlled acts (RHPA), authorized acts (RTA) and acts that Respiratory Therapists may accept delegation for, please refer to the Interpretation of Authorized Acts PPG (crto.on.ca)

This Professional Practice Guideline (PPG) provides information regarding the standards of practice related to the delegation of controlled acts.

[1] ~~For a complete list of regulated health care professionals , and link to their respective websites, please visit the Federation of Health Regulatory Colleges of Ontario (FHRCO) at: http://ipc.fhrco.org/~~

[2] ~~See PPG Interpretation of Authorized Acts Table 1 for a comparison of the controlled acts (RHPA), authorized acts (RTA) and acts that Respiratory Therapists may accept delegation for.~~

Where RTs get the authority to do what they do

RTs gain their legal authority to perform controlled acts in one of three ways:

Legislative Authority	Delegation	Emergency Exception
• the RTA authorizes 5 controlled acts to RTs • no other authorization is required (apart for a valid order for authorized acts 1, 2 & 4)	• certain controlled acts that have not been authorized to RTs may be delegated • delegation is formal process that must be **planned for in advance** and include an **educational component** • delegation is an appropirate authorizing mechanism when the performance of a task is **anticipated** • a valid order is still required • controlled act must be within the professional scope of Respiratory Therapy	• controlled act that have not been legislatively authorized or delegated may (in certain cirsumstances) be performed in under the emergency exception in the RHPA • the emergency exception is an appropirate authorizing mechanism only when when the performance of a task is **not anticipated** • a valid order is ideal but not alway possible to obtain in these types of situations

For example:

Legislative: RT's do not require delegation to intubate as they are legislatively permitted to do so under the Respiratory Therapy Act. Only an order (and competence to do so) is required.

RT's do not require delegation to administer a vaccine as they are legislatively permitted to administer a substance by injection. Only an order (and competence to do so) is required.

Delegation: RT's require delegation and an order to perform allergy testing because they are not permitted legislatively to do so.

RT's require delegation and an order to use an ultrasound for guided catheter insertions because they are not permitted legislatively to apply a form of energy.

RT's can not accept delegation to perform a controlled act that is outside of their professional scope, for example, casting a fracture.

Emergency Exemption: If, in an emergency, an RT was required to defibrillate and there was no one available to delegate it to them (e.g., physician), nor someone else who was legislatively authorized to do so, it would be reasonable, and in the patient's best interest, for the RT to defibrillate. This would be considered a task that was not anticipated and/or an emergency. There may or not be an order at the time.

Delegation - what you need to know.

- Delegation is the transfer of legal authority to perform a controlled act (or "procedures involving one or more controlled acts) ~~act~~ to an individual ~~person~~ not authorized to perform that controlled act.
- ~~Delegation often refers to the transfer of authority to perform "procedures" involving one or more controlled acts.~~
- Procedures and/or activities that do not involve controlled acts, such as those within public domain (e.g., taking vital signs or performing basic spirometry), do not require delegation, however they may still require orders depending on the practice setting.
- Delegation is a formal PROCESS that is procedure specific and may also be specific to:

    - an individual patient/client;
    - a specific patient/client population;
    - a specific situation;
    - a specific health care provider, or;
    - groups of patient/client populations or health care providers.

- Ordering can not be delegated:
    - While it is permissible to delegate the performance of a procedure involving a controlled act to a health care provider (regulated or non-regulated), it is the position of the CRTO that there is no provision in the RHPA to allow a Physician or any other regulated health care professional to "delegate" the ordering of a procedure involving a controlled act to another health care provider. ~~Refer to the CRTO's Orders for Medical Care PPG (crto.on.ca) (see the CRTO *Medical Directives and the Ordering of Controlled Acts* Position Statement).~~
    - ~~who is not authorized to perform that controlled act, it is not permissible to delegate the ordering of that procedure involving a controlled act to someone else.~~

What is the role of delegation in healthcare delivery?

- **Promote patient safety**
- **Facilitates access to care**
- **More timely and/or efficient services**
- **Improvement in the use of resources**

Authorized Acts

The controlled acts authorized to Respiratory Therapists in the *Respiratory Therapy Act, 1991* (RTA) are:

> *In the course of engaging in the practice of respiratory therapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:*

1. Performing a prescribed procedure below the dermis.
2. Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx.
3. Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx.
4. Administering a substance by injection or inhalation.
5. Administering a prescribed[3] substance by inhalation (this is specific to Oxygen)

The RTA requires an order for all controlled acts authorized to Respiratory Therapists (regardless of practice setting) except* for:

- suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx; and
- Administering a prescribed substance by inhalation[4].

***Please note that, depending on the practice setting, other legislation may require an order even for these acts (e.g., the *Public Hospitals Act*).**

If you have terms, conditions or limitations prohibiting you from performing any respiratory therapy procedures that involve controlled acts, you cannot accept delegation for those procedures. (See CRTO Policies: Graduate Certificate of Registration; Supervision Policy;

Did you know...

The RTA states that the legislated scope of practice of RTs 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.

RTs may only accept delegation for certain controlled acts while acting within their scope of practice. ~~For example an RT may accept delegation to perform allergy testing but not setting or casting a fracture of a bone or a dislocation of a joint. Please refer to the PPG Interpretation of Authorized Acts. Acts Table 1 for more information.~~

Inactive Certificate of Registration Policy)

Registered Respiratory Therapists with an Active Certificate of Registration (with no terms, conditions, or limitations)

- Can delegate
- Can accept delegation

Graduate Respiratory Therapists

- Can not delegate
- Can not accept delegation

Student Respiratory Therapists

- Can not delegate
- Can not accept delegation

Did you know...
Terms, Conditions and Limitations (TCLs) and Student Respiratory Therapists
An RT with TCL's on their Certificate of Registration must be aware of their exact limitations and not accept delegation for procedures they are not permitted to perform. For example: If you decide to suction a patient and there is a limitation on your certificate preventing you from suctioning, then you cannot go ahead and accept delegation to suction.

Student Respiratory Therapists who *were* permitted to perform advanced prescribed procedures below the dermis (under an exemption in the *RHPA*), are *no longer* permitted to perform advanced prescribed procedures once they become GRTs. GRTs are not permitted to accept delegation for these controlled acts ~~in order to proceed*.~~ (See *Registration and Use of Title* PPG and *Certification Programs for Advanced Prescribed Procedures below the Dermis* PPG)

~~***Please note...**GRTs are not permitted to delegate or accept delegation for any controlled act.~~

Did you know...

Authorizing Mechanisms - Orders *and* Delegation

- RTs do not require delegation to perform authorized acts 1, 2 and 4 – but still require an order or medical directive to proceed. (see *Interpretation of Authorized Acts* PPG and *Orders for Medical Care* PPG)

- RTs performing procedures involving delegated controlled acts (e.g., allergy testing) also require a valid order or medical directive to proceed. (see *Orders for Medical Care* PPG. ~~*Medical Directives and the Ordering of Controlled Acts Position Statement*~~)

- The Federation of Health Regulatory Colleges of Ontario (FHRCO) has published interprofessional guides, tools and templates to assist regulated health care professionals to develop processes for delegation and the use of medical directives. The aim of these tools is to meet all the regulated professional standards of practice ~~(see FHRCO's Guide and IPC **eTool**)~~. Home | HPRO (regulatedhealthprofessions.on.ca)

- ~~Procedures and activities that do not involve controlled acts and that fall within the public domain do not require delegation may require still require an order.~~

WHAT IS NOT DELEGATION?

An assignment of responsibility and/or duties is not delegation. Even if you are "assigned" to care for patient/client(s) by your supervisor (e.g., a physician, midwife, nurse practitioner or dentist) you would require proper delegation (and orders) to perform any specific procedures involving controlled acts that are not authorized to you. Another regulated health professional asking or instructing you perform a controlled act in the moment, does not constitute the process of “delegation" or the transfer of their authority to you.

“Assisting” a regulated health professional to perform controlled acts does not mean that his or her authority to perform the controlled act has been transferred to you. In this case you are only assisting with the procedure and do not require delegation.

Teaching someone to perform a controlled act (e.g., a regulated; non-regulated health care provider, or other caregiver) may not be enough. Delegation is a process. For more information regarding the standards of practice of teaching versus delegation and a variety of common practice scenarios, please refer to the PPG *Responsibilities of Members as Educators*.

WHEN IS DELEGATION NOT REQUIRED?

If the procedure is not a controlled act, it is in the **public domain** and delegation is not required. In this case, you may perform the procedure provided you have the **competency** to perform it. Depending on your practice setting you may require an order to proceed.

Did you know...

Public Domain

- Administering an oral medication is not a controlled act and does not require delegation; however administering an oral medication does require an order or a prescription in most practice settings.
- Performing spirometry is not a controlled act and does not require delegation, but does require an order in a hospital or pulmonary function testing (PFT) laboratory.
- ~~Performing cardioversion or allergy testing are controlled acts not authorized to RTs that each require a process for delegation AND an order (or medical directive).~~

RHPA Exceptions

If a procedure involves a controlled act and you do not have the authority to perform it (i.e. the procedure is not one authorized to Respiratory Therapists), you may perform the controlled act in one of the following exceptions allowed by the RHPA *[as listed and numbered in the RHPA]:*

Exception #1:
Giving first aid or temporary assistance in an emergency.

You may perform a controlled act in giving first aid provided you have the competency (knowledge, skills and judgment) to perform the procedure.

If a Respiratory Therapist faces an emergency situation, he or she they should not let fear of prosecution for performing a controlled act hinder their his or her response. The College also encourages Respiratory Therapists and their employers who face emergencies on a regular basis to proactively develop policies and procedures, guidelines, processes for delegation and medical directives to help guide their response (e.g. The use of AED's in a facility where it is anticipated that the RT's will be required to participate as a first responders should have a formal delegation process for that controlled act, which includes education and training) These documents may also serve to provide evidence of competency training and ongoing quality assurance to support the practice of Respiratory Therapists in emergent situations.

Did you know...

The application of energy is a controlled act not authorized to RTs?

Examples of Applying Energy

- An Respiratory Therapist who is an Anaesthesia Assistant) requires delegation and a valid order (or medical directive) for the application of energy to assess neuromuscular blockade during general anesthesia.
- Many acute care organizations (hospitals) have implemented processes to delegate the application of energy (e.g., AED/defibrillation) and the use medical directives to authorize and enable RTs as first responders to defibrillate in a code blue or code pink situation. Many hospitals are also choosing to use automated external defibrillators (AEDs). Respiratory Therapists who practice in hospital settings where codes are expected should ensure they are competent and maintain their ongoing competency to apply energy to the expected standards of their profession, and their employer's, even when using AEDs. RTs practicing in these scenarios, are acting as regulated health care professionals. The process for delegation may include education and training for example as an organizational requirement for RTs to maintain their BCLS, PALS and/or ACLS. Please refer to the CRTO's *Use of automated external Defibrillators (AEDs) by Respiratory therapists* Position Statement.
- As of January 1, 2019, amendments to the Controlled Acts Regulation (O. Reg. 107/96) requires RT's to obtain both delegation and an order in order to use ultrasound to guide the insertion of arterial (e.g., in neonates) and venous catheters req(e.g., internal jugular) is becoming a more common practice for Respiratory Therapists. Under section 7 of the Controlled Acts Regulation 107/96, Members may be exempt from requiring delegation to perform diagnostic ultrasound e.g., to insert an arterial catheter or diagnose a chest pneumothorax in neonates; in certain practice settings (i.e., public hospital). Members would need to ensure their competency to apply ultrasound (see *Scope of Practice and Maintenance of Competency* Position

Exception #2:

Fulfilling the requirements to become a member of a health profession and the controlled act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession.

Student Respiratory Therapists do not require delegation to perform controlled acts provided they are enrolled in a CRTO approved program to become Respiratory Therapists AND the controlled acts are within the scope of practice AND a Member of the College is supervising or directing them.

Exception #3:

Treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;

If you are performing a controlled act in treating a person by prayer or spiritual means in accordance with the principles of your religion you do not need to have the act delegated to you.

Exception #4:

Treating a member of the person's household and the act is controlled act 1, 5 or 6 *(as numbered in the RHPA);* and, the acts that may be performed when treating a member of your household are:

a) Communicating to the member of your household, or ~~his or her~~ their personal representative, a diagnosis identifying a disease or disorder as the cause of symptoms of the member of your household, in circumstances in which it is reasonably foreseeable that the member of your household, or ~~his or her~~ their personal representative, will rely on the diagnosis.

b) Administering a substance by injection or inhalation;

c) Putting an instrument, hand or finger;

- beyond the external ear canal,
- beyond the point in the nasal passages where they normally narrow,
- beyond the larynx,
- beyond the opening of the urethra,
- beyond the labia majora,
- beyond the anal verge, or
- into an artificial opening into the body.

Exception #5:
Assisting a person with ~~his or her~~ their routine activities of living and the act is controlled act 5 or 6 *(as numbered in the RHPA).* The acts that may be performed when assisting an individual with ~~his or her~~ their activities of daily living are:

a) Administering a substance by injection or inhalation,
b) Putting an instrument, hand or finger;
beyond the external ear canal,

- beyond the point in the nasal passages where they normally narrow,
- beyond the larynx,
- beyond the opening of the urethra,
- beyond the labia majora,
- beyond the anal verge, or
- into an artificial opening into the body.

These exceptions mean that a person is not in contravention of the RHPA if they ~~he or she~~ perform the controlled acts under the exceptions listed above.
~~Exemptions~~

A Few Points to Consider...

As a member of the College, you ~~may be~~ will be held to the expected standards of practice of the College and the profession in your performance of a procedure, even if it is performed under the exemptions allowed by the RHPA.

Delegation is not required/necessary when a regulated health professional already has the authority to perform the authorized controlled act.

- E.g., It is not necessary to delegate oxygen therapy administration to a registered Physiotherapist in a hospital setting. Physiotherapists are authorized to perform the controlled act administering a substance by inhalation in the *Physiotherapy Act*.
- ~~E.g., it is unnecessary for RTs to receive delegation from a physician to intubate, because intubation is a controlled act authorized to CRTO Members under the Respiratory Therapy Act. An order (or medical directive) is still required to perform intubation, delegation is not.~~

WHEN IS DELEGATION REQUIRED?

In all practice scenarios not covered by the "public domain" or included in the RHPA "exceptions", the authority to perform a controlled act other than the acts authorized to Respiratory Therapists MUST come from delegation from another competent, regulated health care professional who has the authority to perform the controlled act and who is not prohibited from delegating the procedure by his/her specific College.

CAN I ACCEPT DELEGATION OF PROCEDURES?

Yes, you may accept delegation of controlled acts not authorized to CRTO Members under the RTA when all of the following conditions are met:

1. You reasonably believe that the **delegator** has the authority and competence to perform and to delegate the controlled act. In other words, you have no reason to believe that the delegator is not permitted to delegate the controlled act; and

2. You have the authority to perform the controlled act safely, effectively, competently and ethically. In other words, you have no terms, conditions or limitations on your certificate of registration which may prohibit you from performing the delegated controlled act; and

Please note that Graduate Respiratory Therapists (GRT) are prevented by the terms, conditions and limitations on their certificate of registration from accepting delegation for any controlled act. (e.g communicating a diagnosis). ~~Supervision issue…~~

3. You have the **competency** to perform the controlled act. In other words, your competency to perform the delegated controlled act has been confirmed either directly or indirectly by a regulated health care professional who is also competent and has the authority to perform the procedure; and

4. You have determined that receiving delegation of the controlled act is appropriate giving due consideration to:
   a) the best interest of the patient/client
   b) the known risks and benefits of performing the procedure for the patient/client(s),
   c) the predictability of the outcomes of performing the procedure,
   d) the patient/client's wishes,
   e) the safeguards and resources available in the situation; and
   f) other elements specific to the situation.

When making the decision to accept delegation to perform a controlled act that is not authorized to you under the RTA, you are reminded that authority alone is not reason enough to perform the procedure. You must have the competency to perform the delegated procedure and most importantly, performing the procedure must be in the patient/client's best interests.

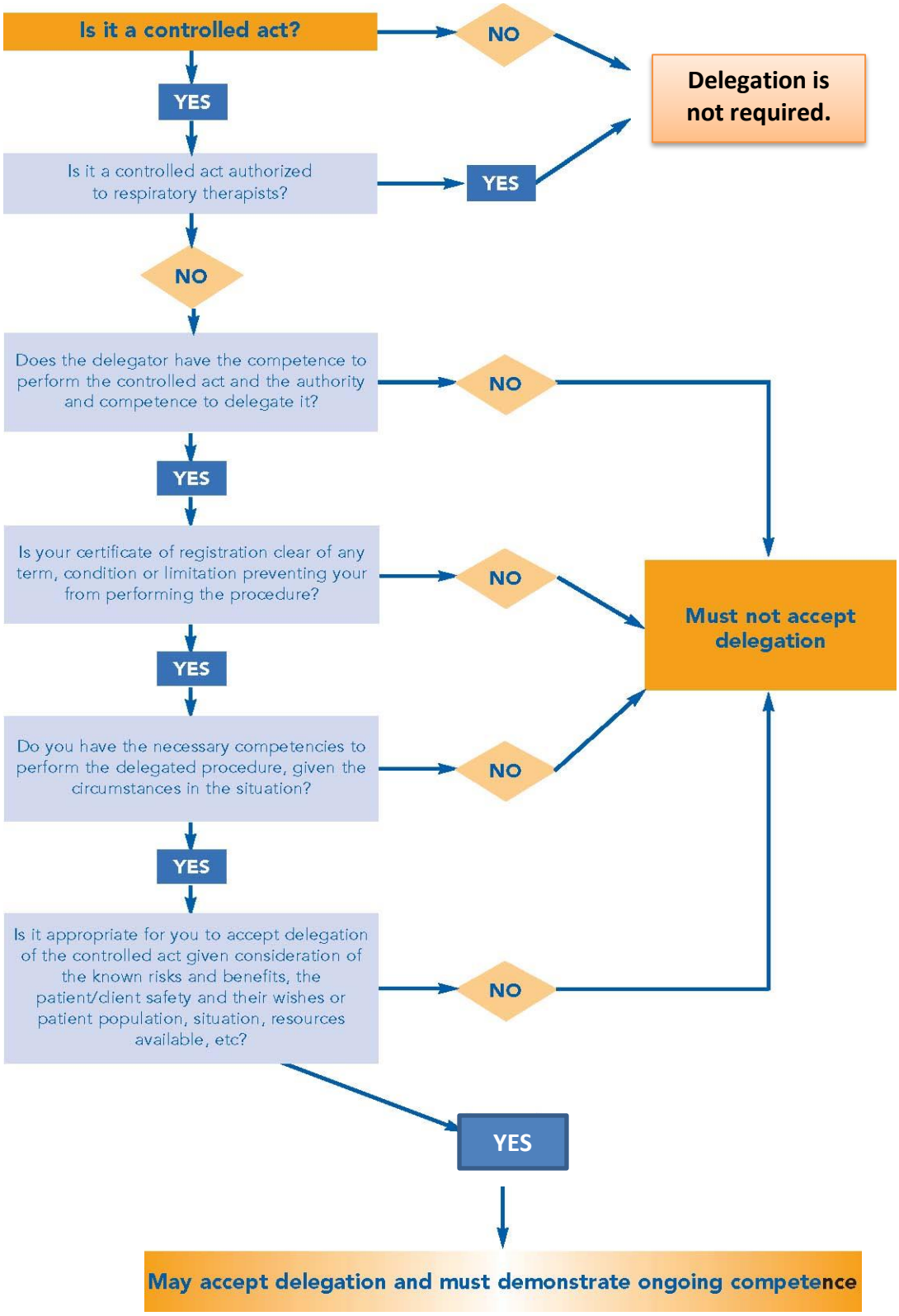
WHO CAN DELEGATE TO ME?

As specified in the RHPA, a Regulated Health Professional with the authority to perform a controlled act is the only person who may delegate a controlled act. (e.g., delegation cannot be received from a committee). It is possible for more than one profession to have the authority to perform and delegate the same controlled act. ~~For more information regarding the scopes of practice of other regulated health care professionals and their controlled acts visit the FHRCO's website.~~

- ~~Scopes of Practice~~
- ~~Scopes Chart~~
- ~~Controlled Acts~~
- ~~Controlled Acts Chart~~

You must not accept delegation from individuals who themselves have received delegation to perform a controlled act procedure. For example, you cannot accept delegation as the authority to perform the controlled act of administering a form of energy (defibrillation) from an unregulated health care provider e.g. EMS paramedic, ~~a Physician's Assistant (PA)~~ who has received delegation from a physician to perform the procedure. In this scenario, the paramedic ~~PA~~, does not have the authority to delegate a controlled under the RHPA. Further, delegated controlled acts may not be delegated over again to another person. This amounts to the concept of "sub-delegation" which is not permitted.

Accepting Delegation Decision Flowchart



WHAT ARE MY RESPONSIBILITIES WHEN I ACCEPT DELEGATION?

You are responsible for the performance of the procedure to the standard of the profession of the delegator or the generally accepted standard of practice of health care practitioners providing similar care. In other words, you must have the requisite competency (knowledge, skills and judgment) to perform the procedure before you accept delegation.

You should also maintain proper documentation of your actions by keeping a record of what activities you accepted delegation and who delegated the activities to you. The preferred method of doing this is to keep records of delegation (and other professional development) in your learning log and Quality Assurance (QA) Portfolio Online for Respiratory Therapists (PORTfolio) . Your competency records regarding delegation should include the following:

- the regulated health care professional (e.g. physician) who has delegated the controlled act;
- the controlled act that have been delegated to you;
- continuing education related to the delegated controlled act; and
- the period of time that the delegation remains in force prior to requiring reconfirmation of ongoing competence in the procedure. (e.g. an organizational requirement that the delegation you receive to perform defibrillation may be time-limited to one year or the expiry date of your ACLS certification , at which time you must once again demonstrate competence in the procedure).

Remember that just because you can accept delegation doesn't necessarily mean that you should accept delegation. CRTO Members must consider whether it is appropriate, safe, and ethical and in the best interest of the patients/clients that you are caring for.

Most employers will have policies and procedures regarding delegation detailing their process for giving and receiving delegation. You should check your employer's policies before accepting delegation. Your employer may also have specific requirements regarding documentation when you accept delegation to perform a controlled act procedure. For more information regarding documentation obligations, please see CRTO's Documentation PPG (crto.on.ca)

DELEGATING RT AUTHORIZED ACTS

CRTO Members may delegate procedures within the controlled acts authorized to Respiratory Therapists, but only when all of the following conditions are met:

1. You have the authority (related to terms, conditions or limitations on your certificate of registration - specifically related to you as an individual or as a holder of a particular class of certificate of registration), and competence (knowledge, skills and judgment) to perform and to delegate the procedure safely, effectively, competently and ethically; and

2. You reasonably believe that the delegatee has acquired, through teaching and clinical supervision of practice, the competence to perform the procedure safely, effectively, competently, and ethically; and

3. You have no reason to believe that the delegatee is not permitted to accept the delegation; and

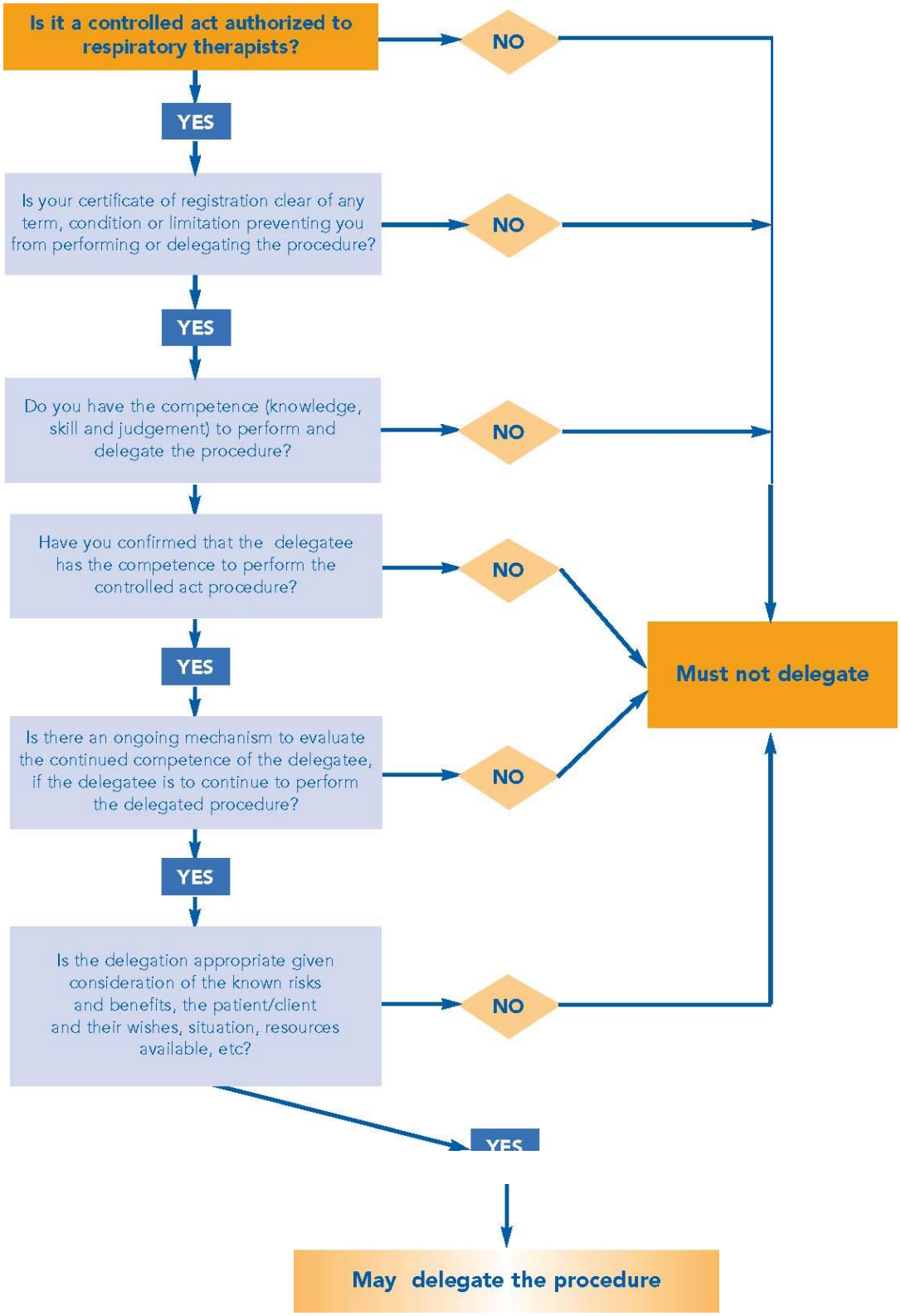
4. You verify, or reasonably believe an evaluation mechanism is in place to verify, the continued competence of the delegatee for performing the procedure; and

5. You have determined that delegation of the procedure is appropriate giving due consideration to:

a) the known risks and benefits of performing the procedure for the patient/client(s);
b) the predictability of the outcomes of performing the procedure;
c) the patient/clients' wishes;
d) the safeguards and resources available in the situation; and
e) other elements specific to the situation.

Please note…Due to the fact that tracheostomy tube changes are now listed as an exemption in the *Controlled Acts* regulation, respiratory therapists (RRT, GRT and PRTs) are no longer permitted to delegate tracheostomy tube changes

Delegation Decision Flowchart



WHAT PROCEDURES CAN I DELEGATE?

CRTO members may delegate any **RT authorized act** procedures to another regulated or non-regulated health care provider provided they meet their professional responsibilities which are outlined below.

WHAT ARE MY RESPONSIBILITIES WHEN I DELEGATE?

- You meet the Standards of Practice of the College and the profession before delegating a procedure
- Confirm that the individual can safely perform the procedure to the same, accepted standard
- Ensure a mechanism exists for education, supervision, and on-going competence evaluation of the delegate

~~You are responsible for ensuring that a mechanism exists for education, supervision, and on-going competence evaluation of the delegatee. You should never assume that the individual has the necessary competencies to perform the controlled act procedure that you are authorizing to them through delegation. You must confirm or validate that they can safely perform the procedure to the same standard that you would perform the procedure.~~

~~In practical terms, this confirmation might mean that that you alone are the person performing all of the components of the confirmation of competence (education, supervision, evaluation) or you may be part of a team. You must ensure that you meet the standard of practice of the College and the profession before you delegate a procedure. You are responsible for delegating the procedure and the delegatee is responsible for accepting and performing the procedure.~~

Assuming responsibility for the delegation does not mean you assume responsibility for the delegatee's performance of an individual procedure. It is your responsibility to ensure that, given consideration to all circumstances, the delegation is appropriate. As with any other intervention you undertake, it is your responsibility to ensure proper documentation of your actions by keeping records of the individuals to whom you delegate and the specifics of the procedures that you delegate. CRTO Members are encouraged to keep records of what and to whom they have delegated in their QA PORTfolio.

Records should include the following:

- description of the procedure being delegated,
- information related to the education that was provided to the delegatee (number of hours, curriculum, any handouts, tests, etc.),
- who provided it (yourself or a team of RRTs for example);

- description of the "certification process", and
- the quality management activities and any particular specifics related to ongoing quality monitoring and evaluation of the delegation.

Your employer may have specific requirements regarding delegation and documentation that you will need to be familiar with prior to delegating.

You are professionally accountable for your decision to delegate a procedure and you must ensure you have satisfied all the requirements outlined in this practice guideline. The "reasonably believe" concept requires that you act prudently. For example, if your employer has a policy that outlines an evaluation process for assessing the competence of delegatees, that you know in practical terms is not adhered to, it is your obligation not to delegate procedures until the reality matches the policy. It also means that you do not personally have to supervise, teach, and evaluate a delegatee but you are responsible to ensure that an appropriate process is in place. If you are reasonably satisfied that a certification program appropriately assesses competence, then it would be reasonable to accept that successful completion of the program means that an individual has the requisite competence to perform the procedure.

Making a decision to delegate your authority to perform a controlled act to another individual should not be taken lightly. The ultimate decision to delegate rests with you.

(Please refer to the PPG Responsibilities of Members as Educators for more standards of practice related to teaching and delegation.)

UNDER WHAT CIRCUMSTANCES AM I NOT PERMITTED TO DELEGATE?

You must not delegate a controlled act procedure:

1. That is not authorized to you according to the Respiratory Therapy Act. For example, you cannot delegate a controlled act procedure, which you yourself require delegation from another RHP to perform (for example, ultrasound guided line insertion). This amounts to the concept of "sub-delegation" which is not permitted;

2. To an RHP (including a Respiratory Therapist) who is prevented from performing the procedure due to terms, conditions, or limitations on his or her certificate of registration; or

3. To an individual who you do not reasonably believe has the competence to perform the procedure.

Did you know...

CRTO members who hold a General Certificate of Registration may not delegate an RT authorized act to a member with a Graduate certificate of registration, who is prohibited from performing the procedure due to terms, conditions and limitations on their certificate. For example, an RRT may not delegate chest tube insertion to a GRT.

WHAT ARE THE PENALTIES IF I PERFORM A CONTROLLED ACT WITHOUT THE AUTHORITY TO DO SO?

If you or another RHP perform a controlled act when you are not permitted to do so, you may be subject to professional misconduct proceedings. (See Professional Misconduct Regulation provision 1.4).

Glossary

Authority the right to act - usually related to **jurisdiction provided in a statute or to** terms, conditions or limitations imposed on a certificate of registration - individually specified (by a panel) or related to an entire class of certificates of registration (specified by Council or a panel)

Authorized act is a controlled act, or portion of a controlled act, that is authorized within a health profession act for a health professional to perform [there are 4 acts authorized to Respiratory Therapists by the Respiratory Therapy Act, that are created from 3 controlled acts defined in the RHPA]; the controlled acts authorized to Respiratory Therapists are:

1. Performing a prescribed procedure below the dermis;
2. Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx;
3. Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx;
4. Administering a substance by injection or inhalation; and
5. Administering a prescribed substance by inhalation.

Controlled act one of the following 13 acts defined in the RHPA [section 27(2)] when it is performed "with respect to an individual":

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
    i) beyond the external ear canal,
    ii) beyond the point in the nasal passages where they normally narrow,
    iii) beyond the larynx,
    iv) beyond the opening of the urethra,
    v) beyond the labia majora,
    vi) beyond the anal verge, or
    vii) into an artificial opening into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling or compounding a drug as defined in subsection 117 (1) of the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception, or memory that may seriously impair the individual's judgement, insight, behavior, communication or social functioning.

Competence having the requisite knowledge, skills and judgement to perform the procedure

Delegatee the person receiving the authority to perform a procedure

Delegator the person conferring the authority for another to perform a procedure

Emergency when the patient/client is apparently experiencing severe suffering or is at risk, if the procedure or treatment is not administered promptly, of sustaining serious bodily harm.

Forms of energy the following forms of energy are prescribed in regulation:

1. Electricity for,
    - i) aversive conditioning
    - ii) cardiac pacemaker therapy
    - iii) cardioversion
    - iv) defibrillation
    - v) electrocoagulation
    - vi) electroconvulsive shock therapy
    - vii) electromyography
    - viii) fulguration
    - ix) nerve conduction studies, or
    - x) transcutaneous cardiac pacing

2. Electromagnetism for magnetic resonance imaging
3. Soundwaves for,
    i) diagnostic ultrasound, or
    ii) lithotripsy

HPPC Health Professions Procedural Code - RHPA; Schedule 2

Member a member of a regulatory college under the RHPA

Reasonably sensible, rational - often referred to as the reasonable person test - determined by case law - in the case of the College, a panel would determine whether or not an individual, giving consideration to all circumstances, acted in a sensible, rational manner in the matter under discussion

Respiratory Therapist - a Member of the CRTO (refers to RRT, GRT, PRT, Inactive Member)

RHP Regulated Health Professional - a health care provider who is a member of a College and is regulated by the RHPA (e.g., nurse, physician, dentist, massage therapist, physiotherapist, dietitian, occupational therapist, etc)

RHPA *Regulated Health Professions Act, 1991*

RTA *Respiratory Therapy Act, 1991*

References

College of Nurses of Ontario (~~2006~~ 2020). *Practice standard: Decisions about procedures and authority.* Retrieved ~~February 7, 2007~~ from
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College of Physicians and Surgeons of Ontario (~~2004, November~~2021, March). ~~*Policy #4-03:*~~
Delegation of controlled acts. Retrieved ~~February 7, 2007~~ from
~~www.cpso.on.ca/Policies/delegation.htm~~
https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Delegation-of-Controlled-Acts

College of Respiratory Therapists of Ontario (~~2004, April~~ 2020, March). *Professional practice*
guideline: Interpretation of authorized acts. Retrieved ~~February 7, 2007~~ from
~~www.crto.on.ca/pdf/ppginterpauthoracts.pdf~~
https://www.crto.on.ca/pdf/PPG/interpretation.pdf

~~Federation of Health Regulatory Colleges of Ontario (2007). *An interprofessional guide on the use of orders, directives and delegation for regulated health professions in Ontario.* Retrieved February 7, 2007 from~~
~~www.medicaldirectives-delegation.com/why/~~

An Interprofessional Guide on the use of Orders, Directives and Delegation for Regulated Health Professionals (2021) Health Profession Regulators of Ontario. Retrieved from: http://www.regulatedhealthprofessions.on.ca/orders%2c-directives%2c-delegation.html

Legislation

Regulated Health Professions Act, 1991. (see s27)
www.e-laws.gov.on.ca/DBLaws/Statutes/English/91r18_e.htm

Respiratory Therapy Act, 1991.(see s4)
www.e-laws.gov.on.ca/DBLaws/Statutes/English/91r39_e.htm

Prescribed Substance Regulation
O. Reg. 596/94: GENERAL (ontario.ca) (see Part VII.1)

1999: Revised February 2003; Revised January 2004; Revised September 2005; Revised February 2007; Revised February 2013; Revised August 2021.

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

~~Professional Practice Advisor~~
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AGENDA ITEM # 4.8 **September 24, 2021**

From:	*Kelly Arndt RRT, Quality Practice Coordinator*
Topic:	*Draft Revised Interpretation of Authorized Acts (IAA) Professional Practice Guideline (PPG)*
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 - AED Position Statement Appendix B - Current Interpretation of Authorized Acts (IAA) PPG Appendix C – Revised Interpretation of Authorized Acts (IAA) PPG

PUBLIC INTEREST:

Ensuring that Respiratory Therapists understand their professional and legislative requirements and responsibilities when applying of a form of energy, either ultrasound or AED.

ISSUE:

Previously revised in March 2020, the IAA PPG has been revised to incorporate the previous position statement regarding the Use of AED's by Respiratory Therapists and create a more concise source of information.

BACKGROUND:

Under the new CRTO's policy framework, the combination of these two documents will provide clear direction and expectations in the application of a form of energy and provide a better understanding of the ordering mechanism and delegation requirements.

RECOMMENDATION:

It is recommended that the CRTO Council review and approve the revised Interpretation of Authorized Acts PPG for circulation for feedback from members and stakeholders.

NEXT STEPS:

If the motion is approved, the PPG will be circulated for public consultation and review. A final draft will be presented at the December 2021 Council meeting.

AGENDA ITEM # 4.8

Motion Title:	*Draft Revised Interpretation of Authorized Acts Professional Practice Guideline*
Date of Meeting:	*September 24, 2021*

It is moved by _____ and seconded by _____ that:

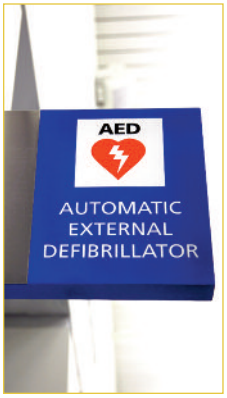
Council approves the *Draft Revised Interpretation of Authorized Acts Professional Practice Guideline* for circulation and feedback. (A copy is attached as Appendix C to this motion within the materials of this meeting.).

Use of Automated External Defibrillators (AEDs) by Respiratory Therapists Position Statement for reference.

Use of Automated External Defibrillators (AEDs) by Respiratory Therapists

POSITION STATEMENT

According to the American Heart Association's 2010 Guidelines for CPR and ECC, the combination of CPR and early access to defibrillation have been shown to significantly increase the odds of survival from a cardiac arrest (Heart and Stroke Foundation of Canada, 2013). Early defibrillation in the community setting is facilitated through widespread use of Automated External Defibrillators (AEDs), designed for use by a layperson. In a hospital or other health care setting, health care providers are held to their professional standards for any intervention and, because the use of a defibrillator involves the performance of a controlled act (the application of a form of energy), their use must be appropriately authorized. This position statement outlines the responsibilities for Respiratory Therapists when using an AED in a health care setting.



Can Respiratory Therapists Use AEDs in the Event of a Cardiac Arrest?

Yes, provided that the proper authorization has been obtained. Authorization can exist either (1) through the use of an order and delegation or, should those not be available, (2) through the emergency exception of the *Regulated Health Professions Act, 1991 (RHPA)*.

How to Authorize the Use of an AED

The use of an AED involves the application of a form of energy, which is listed as a controlled act in the *Regulated Health Professions Act, 1991 (RHPA)*. This particular controlled act is not authorized to Respiratory Therapists (RTs) under the *Respiratory Therapy Act, 1991*, so the use of an AED can only be performed if authorized by:

1. An order and delegation, or;
2. Exercise of the emergency exception in the RHPA.

Ultimately, you must be authorized to use the AED one way or the other, yet the circumstances of each situation will dictate which would be most appropriate.

1. Order and Delegation

The preferred authorization mechanism is the combination of an order and delegation. Under this approach, the **order** serves to authorize the use of the AED (the application of energy) and the **delegation** *transfers* that authority to the RT. Ideally, this is done "in the moment" on a case-by-case basis, although this may not be practical in the urgency associated with the management of a cardiac arrest. As such, it is permissible to use a standing medical directive and delegation that would apply in these scenarios (i.e., an organization-wide medical directive and delegation that allows any RT who has been trained in the use of AEDs to apply them in specified situations, such as a cardiac arrest).

2. Emergency Exemption

There is an emergency provision in the *RHPA* that allows for an exception to the restriction on controlled acts. This exception assumes that performance of the controlled act in question is not carried out frequently and that it is truly an emergency. Further, it is important to distinguish between an unforeseen emergency and a "regular" emergency. This distinction is recognized in the *Good Samaritan Act, 2001*, which provides immunity from negligence lawsuits for health professionals who provide "emergency health care services or first aid assistance" at a place other than a hospital or health care facility, thereby implying that those are unforeseen emergencies, whereas the work they do IN hospital and health care facilities are "regular" emergencies. The combination

of an order and delegation would be the most appropriate approach for managing "regular" emergencies, although clearly not all cardiac arrests are foreseeable. Therefore, it is acceptable for an RT to apply an AED under the emergency exception, yet ***only*** in circumstances where an order and delegation are not available.

Applying Your Professional Judgement

In any situation, each RT should exercise his/her professional judgement to ensure that use of an AED is both indicated and appropriate, that he/she has the knowledge and skills to use the AED appropriately and afterwards, as with any intervention, the use of the AED should be documented accordingly.

Resources

Regulated Health Professions Act, 1991:
www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm

Respiratory Therapy Act, 1991:
www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r39_e.htm

Federation of Health Regulatory Colleges, Guide to Medical Directives and Delegation:
www.regulatedhealthprofessions.on.ca/EVENTSRESOURCES/medical.asp

Good Samaritan Act, 2001:
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_01g02_e.htm

The **College of Respiratory Therapists of Ontario (CRTO)**, through its administration of the ***Regulated Health Professions Act*** and the ***Respiratory Therapy Act*** is dedicated to ensuring that respiratory care services provided to the public by its Members are delivered in a safe and ethical manner. The CRTO has developed this Position Statement, on the issue of AEDs by Respiratory Therapists and believes that the position outlined, and the guidance provided, serve both the interest of the public and the Members of the College, by ensuring that the appropriate health care providers who perform procedures involving controlled acts are authorized to do so in accordance with the legislation/regulations/policies and/or guidelines that govern their practice.

College of Respiratory Therapists of Ontario

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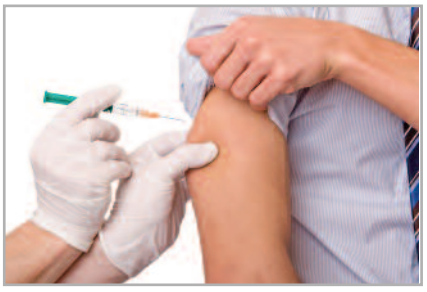
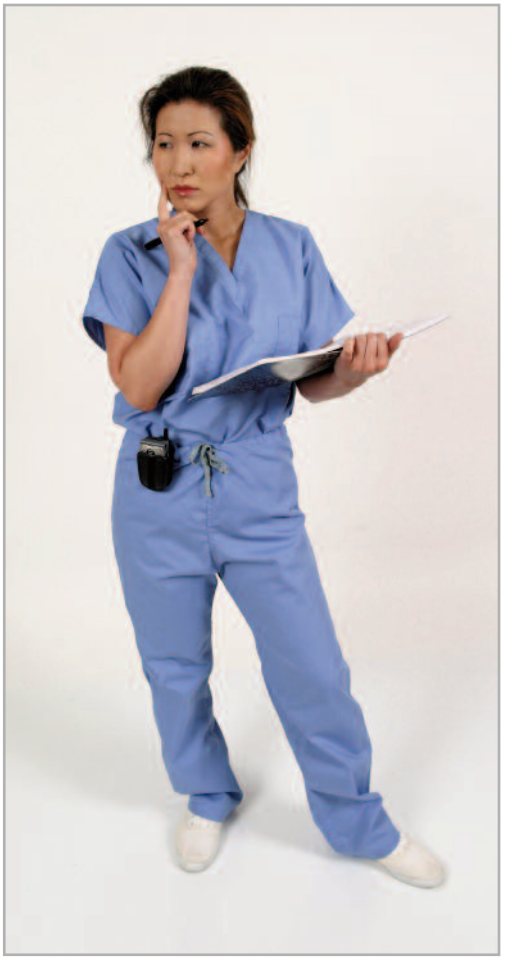
Current Interpretation of Authorized Acts PPG for reference.

March 2020

Interpretation of Authorized Acts

PROFESSIONAL PRACTICE GUIDELINE





Professional Practice Guideline

CRTO publications containing 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. All Members are required to abide by these CRTO publications, and they will be used in determining whether appropriate standards of practice and professional responsibilities have been maintained.

It is important to note that employers may have policies related to an RT's ability to accept delegation to dispense medications. 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.

Table of Contents

Scope of Practice of Respiratory Therapy

The scope of practice outlined in the *Respiratory Therapy Act* (*RTA*) states:

> *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 (RTA. s.3)*

While the **professional scope of practice**, as defined by the *RTA*, is broad, each RT has their own **personal scope of practice** that is influenced by factors such as their role within their specific practice setting. It is important to remember that having the authority to perform a controlled act does not mean it is appropriate to do so. The CRTO's Standards of Practice states that a Respiratory Therapist must practice within both the professional scope of practice and their personal scope of practice (Standard 4 – Competence/Ongoing Competence).

It is also important to note that not all tasks that might fall under a particular authorized act are within the scope of practice of Respiratory Therapy.

For Example...

"Administering a substance by injection or inhalation" is a controlled act authorized to RTs. This enables RTs are to administer medications by injection that are within the RT scope of practice (e.g., flu vaccines, procedural sedation, etc.). However, medications such as forms of botulinum toxins (i.e., Botox) are outside of the RT scope of practice. Therefore, to administer those types of substances, a formal delegation process is required.

Controlled Acts

The *Regulated Health Professions Act, 1991 (RHPA)* identifies 14 **controlled acts** that pose significant risk of harm to the public of Ontario [*RHPA* section 27(2)]. These acts may only be performed by the regulated health care professionals who are authorized by their profession-specific Acts (e.g., *Respiratory Therapy Act* (RTA)).

If that authority has not been granted to an individual via their professional specific legislation, there are two alternative processes by which a controlled act can be performed, which are as follows:

1. **Legislative Exceptions & Exemptions**
   The *RHPA* identifies certain exceptions where an individual may perform controlled acts even if they do not have the necessary authority to do so, and these are outlined in the Exceptions within the RHPA section of this practice guideline. In addition, there are exemptions in other legislation that enables Respiratory Therapists and other healthcare professions to perform other specific tasks. This is outlined in the Exemptions within the Controlled Acts Regulation section of this practice guideline.

2. **Delegation**
   Authority to perform a controlled act may be obtained through the process of delegation from a regulated health professional who has the authority to perform the controlled act to another person (regulated or unregulated), who does not have this authority. The controlled acts that are not authorized to Respiratory Therapists but that could be delegated are outlined in the Delegation of Controlled Acts Not Authorized to Respiratory Therapists section of this practice guideline.

Public Domain

If a task is not a controlled act, then it is considered to be in the public domain and may be performed by anyone (regardless of whether they are a regulated healthcare professional or not), provided they are competent to do so. Regulated health professionals must adhere to the standards of practice of their respective profession while performing activities that fall within the public domain.

Examples of Public Domain Tasks...

1. Administering an oral medication;
2. Spirometry (with no bronchodilators)

The *Respiratory Therapy Act* (*RTA*) is the profession-specific legislation that lists the five controlled acts authorized to Respiratory Therapists (RTs)* in Ontario. These five controlled acts are referred to as the profession's authorized acts** and are as follows:

1. *Performing a prescribed procedure below the dermis.*
2. *Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx.*
3. *Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx.*
4. *Administering a substance by injection or inhalation.*
5. *Administering a prescribed substance by inhalation.*

* In this practice guideline, "Respiratory Therapists (RTs)" refers to CRTO Members who hold an Active General Certificates of Registration with the CRTO with no terms, conditions or limitations preventing them from performing any authorized acts. Graduate Respiratory Therapists (GRTs) and Practical (Limited) Respiratory Therapists (PRTs) have specific terms, conditions and limitations that are outlined below.

** All five authorized acts may be performed on adult, pediatric and neonatal populations.

PLEASE NOTE:

Authorized Act #4 enables **RRTs**, **PRTs** & **GRTs** to perform all procedures that fall under the authorized act Administering a substance by injection or inhalation, **provided they have a valid order**.

Authorized Act #5 enables only **RRTs** to administer a substance that is "prescribed" in regulation. In this case, the regulation is the *Prescribed Substance Regulation* and the substance is oxygen. **This authorized act does not have the requirement of an order.** Therefore, an RRT can independently administer oxygen, provided they are not prevented from doing so by any other piece of legislation or polices. More information can be found on this act in the Administering a prescribed substance by inhalation section of this practice guideline.

Performing a prescribed procedure below the dermis

In this first authorized act, "prescribed" means prescribed in regulation. The *Prescribed Procedures Regulation* lists the specific procedures included under the controlled act of "performing a prescribed procedure below the dermis" and separates them into two categories: basic and advanced. Table 1 outlines what procedures are contained within the regulation and provides some examples of specific procedures. Please note that the list of examples is not exhaustive and is offered simply as a point of clarification.

Table 1: Prescribed Procedures below the Dermis

Procedure	Examples
Basic	
i. Arterial, venous, and capillary puncture.	• Arterial Blood Gas.
ii. Insertion, suturing, aspiration, repositioning, manipulation and removal of an arterial cannula.	• Arterial line.
iii. Insertion, suturing, aspiration, repositioning, manipulation, and removal of a venous cannula.	• Peripheral IV • Internal Jugular Vein cannulation
Advanced	
i. Manipulation or repositioning of a cannula balloon.	• Pulmonary Capillary Wedge Pressure (PCWP). • Intra-Aortic Balloon Pump (IABP)
ii. Chest needle insertion, aspiration, reposition, and removal.	
iii. Chest tube insertion, aspiration, reposition and removal.	
iv. Bronchoscopic tissue sample for the purpose of bronchoalveolar lavage and endobronchial brushing.*	
v. Intraosseous needle insertion.	
vi. Subcutaneous electrode placement for interoperation and perinatal fetal monitoring.	

* Tissue biopsy is not included as part of this procedure because it requires the sample to be taken below the mucous membrane, which is not authorized to RTs. To perform a tissue biopsy, delegation is required.

- To perform any procedure classified as Advanced, a Registered Respiratory Therapist (RRT) must have completed a CRTO approved certification/recertification program within the past two years. More information is available in the CRTO's Certification Programs for Advanced Prescribed Procedures below the Dermis PPG.

- Graduate Respiratory Therapists (GRTs) and Practical Respiratory Therapists (PRTs) must not perform any procedure classified as Advanced, even if they have successfully completed an approved certification program.

- PRTs must not perform any procedure classified as Basis unless they have been granted to do so by the CRTO's Registration Committee (i.e., have specific terms and conditions applied to their certificate of Registration).

Table 2: Procedures Below the Dermis & Tracheostomy Tube Changes.

Procedure	RRT	GRT*	PRT
Basic prescribed procedures.	✓	✓	**
Advanced prescribed procedures.	✓		

Regional Anesthesia

The insertion of spinal, epidural blocks and peripheral nerve blocks are not authorized under the current *Prescribed Procedures* regulation; therefore, delegation is required. The injection of medication through these routes; however, falls under *"administering a substance by injection or inhalation"*, which is authorized to RTs.

Authorized Act #2

Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx

The second controlled act authorized to RTs is *intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx*. "Beyond the larynx" is interpreted by the CRTO as at or below the level of the larynx, whether you are referring to the airway or the esophagus, including access by oral, nasal, and artificial opening routes.

Examples of tasks an RT can perform under this authorized act are:

- Endotracheal intubation, including nasal and oral routes, as well as bronchoscopic assisted techniques;
- Laryngeal mask insertion;
- Nasogastric tube insertion and the insertion of specially designed nasogastric tubes with EMG electrodes that cross the diaphragm for the purpose of Neurally Adjusted Ventilatory Assist (NAVA);
- Nasal airway insertion; and
- Feeding tube insertion.

Authorized Act #3

Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx

The third controlled act authorized to RTs is *suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx*. Beyond the larynx is interpreted as at or below the level of the larynx, whether you are referring to the airway or the esophagus, including access by oral, nasal, and artificial opening routes.

An RT may perform suctioning via a number of routes, including nasopharyngeal, tracheal, nasogastric, and bronchoscopic. The RTA does not require an order for this authorized act; however, other pieces of legislation may have an impact on whether or not an order is required (e.g., *Public Hospitals Act* – Hospital Management Regulation). In addition, an RT must comply with their employer's policies and procedures regarding suctioning.

Administering a substance by injection or inhalation

The fourth controlled act authorized to RTs is *administering a substance by injection or inhalation*.

1. Under this act, an RT may administer a substance by inhalation in the following forms:
    - **Liquids** (e.g., surfactant, epinephrine instillation)
    - **Powders** (e.g., Turbuhaler™, Diskus™)
    - **Aerosols** (e.g., wet nebulization, bronchodilators, narcotics, antibiotics, bronchoprovocators (e.g., Methacholine))
    - **Gases**
        - anesthetic (e.g., Nitrous oxide)
        - non-anesthetic (e.g., Oxygen, Heliox, Nitric Oxide, Compressed Air)
        - specialized (e.g., Carbon Monoxide, Helium, Nitrogen)
        - pressurized (e.g., invasive and non-invasive positive pressure ventilation - including CPAP, BiPAP, Hyperbaric Oxygen Therapy)
    - **Vapors** (e.g., anesthetic agents such as Isoflurane)

2. Under this act, an RT may administer substances by injection via the following routes:
    - **Intravascular** (e.g., Intravenous D5W, Normal Saline, Ringers Lactate, blood products)
    - **Intramuscular** (e.g., Vaccines, Vitamin K, Narcan, Epinephrine)
    - **Intradermal** (e.g., TB test)
    - **Sub-cutaneous** (e.g., Xylocaine, Heparin)

PLEASE NOTE:

Vaccines administered by RTs must only be those recommended in established guidelines (e.g.,ATS, CTS) for the management of cardiorespiratory and associated disorders (e.g., Influenza, Pneumococcal Pneumonia).

Non-Invasive Positive Pressure Ventilation (NIPPV)

It is the position of the CRTO that air that has been augmented, whether by changing the concentration of the constituent gases (e.g., adding oxygen) or by adjusting the pressure beyond atmospheric, constitutes *"administering a substance by…inhalation"*. Therefore, the application of NIPPV is a controlled act and should only be performed by health care professionals who have the statutory authority (4th authorized act in the *Respiratory Therapy Act*) as well as the requisite education, training and clinical competence.

Administering a prescribed substance by inhalation

The *Prescribed Substances Regulation* currently lists oxygen as the substance that RTs can administer. RRTs, PRTs & GRTs have always been able to - and still are able to - administer oxygen on the order of a physician, midwife, dentist or nurse practitioner. The difference with the 5th authorized act is that, similar to suctioning, it does not have the requirement of an order. This means that RRTs, depending on where they work, can independently initiate, titrate or discontinue oxygen-based solely on their own professional judgment. **Please note that this authorized act only applies to RRTs.**

It is important to understand, however, that there are other pieces of legislation and policies that limit where RTs can independently administer oxygen. The most applicable piece of legislation, in this instance, is the *Public Hospitals Act – Hospital Management Regulation*, which stipulates that every act performed in a public hospital requires an order and limits who can provide those orders. However, this restriction does not apply to non-public hospital/community practice settings (e.g., Home Care, Family Health Teams, private community-based clinics, etc.).

In addition, the Home Oxygen Therapy Policy and Administration Manual (October 2019) currently stipulates that the initiation and discontinuation of oxygen must be ordered by a physician and that any changes to the prescription are the responsibility of the ordering physician.

For more information, please refer to the *Oxygen Therapy CBPG* and the Independent Administration of Oxygen FAQ.

For Example...

An RRT working in the community who has been asked to provide oxygen to a patient who is self-paying for the therapy. In this situation, the RRT may initiate, titrate and/or discontinue therapeutic oxygen based solely on their own professional judgement. The RRT must make their own determination on the patient's oxygen settings and set their own fee structure. As with any situation when charging for clinical services, the RRT will need to ensure that:

1. the therapy is clinically indicated;
2. they are not in a conflict of interest;
3. the patient is making a fully informed decision on their course of care; and
4. they are charging a fair and reasonable rate for their services*.

*Currently, RRTs do not have the ability to bill OHIP for services.

Hyperbaric Oxygen Therapy (HBOT)

The 5th authorized act, in combination with the *Prescribed Substances regulation*, permits RTs to independently administer therapeutic oxygen. Therefore, in a hyperbaric clinic located outside of a hospital, RRTs can administer oxygen without the additional requirement of an order from a physician or other authorizer. However, this administration of oxygen must occur in accordance with a diagnosis and prescribed treatment plan (e.g., dive depth/pressure, time, etc.) that has been determined by the most responsible physician. RRTs cannot independently initiate hyperbaric therapy.

In both the hospital and community setting, certification as a Hyperbaric Technologist by the Undersea and Hyperbaric Medical Society (UHMS) sets the industry standard and that any RRT administering HBOT would be expected to perform to. In the *Oxygen Therapy CBPG*, the CRTO outlines 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. Therefore, the CRTO does not endorse "off label" use of HBOT and the engagement of an RT in such activity by an RT may be considered professional misconduct (*Professional Misconduct Regulation (s.7) - Recommending, dispensing or selling medical gases or equipment for an improper purpose*). In addition, the CRTO's Standards of Practice states that RTs must refrain from making a representation about a remedy, treatment, device or procedure for which there is no generally accepted scientific or empirical basis. (Standard 8 – Evidence Informed Practice)

When determining if it is appropriate to perform an authorized act, an RT must first consider the following:

- *Is the performance of the authorized act in the best interest of the patient?*
- *Do they possess the requisite competencies (knowledge, skills & abilities) to perform the authorized act safely?*
- *Is the performance of this particular task within the Scope of Practice of Respiratory Therapy?*
- *Does their Certificate of Registration permit them to perform it (i.e., do they hold the appropriate certificate of registration required, and are there any terms, conditions, or limitations on their Certificate of Registration preventing them from performing this task?)*
- *Is an Authorizing Mechanism (Direct Order or Medical Directive) required to perform this authorized act, and, if so, do they have a valid order (direct order or medical directive) from an authorized prescriber?*

As mentioned at the beginning of this practice guideline, other methods of gaining the authority to perform a controlled act are delegation and exceptions that exist within specific pieces of legislation, such as the RHPA and the Controlled Acts Regulation.

Delegation of Controlled Acts Not Authorized to Respiratory Therapists

RTs may, in some specific circumstances, receive delegation to perform a controlled act that is not authorized to Respiratory Therapists. This is permitted provided the specific task to be performed falls within the Scope of Practice of Respiratory Therapy. The controlled acts that RTs are permitted to accept delegation are as follows:

- *Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.* (*RHPA* s.27 (2)1)

- *Putting an instrument, hand or finger,*
  - *beyond the external ear canal,*
  - *beyond the opening of the urethra,*
  - *beyond the labia majora,*
  - *beyond the anal verge,*
  - *into an artificial opening into the body.* (*RHPA* s.27 (2)6)

- *Applying or ordering the application of a form of energy prescribed by the regulations under the RHPA.** (RHPA s.27 (2)7)
  *The Controlled Acts Regulation (Forms of Energy) outlines the specific tasks that fall under this controlled act.

- *Dispensing a drug as defined in the Drug and Pharmacies Regulation Act.** (*RHPA* s.27 (2)8)
  * RTs are not permitted to receive delegation for the other portions of this controlled act, which are prescribing, selling, or compounding a drug and supervising the part of a pharmacy where such drugs are kept. More information on Dispensing is available in the CRTO's Administering and Dispensing Medications PPG.

- *Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.* (*RHPA* s.27 (2)13)

More information on the delegation process is available in the CRTO's Delegation of Controlled Acts Professional Practice Guideline (PPG).

Exceptions within the *RHPA*

The *RHPA* contains certain exceptions that enable someone who is not otherwise authorized to perform a controlled act in specific circumstances, provided they have the requisite competence (knowledge, skills, and judgment) to perform the task safely. The exceptions outlined in the *RHPA* are as follows:

- *Rendering first aid or temporary assistance in an emergency;* (*RHPA* s.29 (1)a)
- *Fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession;* (*RHPA* s.29 (1)b)

PLEASE NOTE:

Student RTs do not require delegation to perform controlled acts. They are permitted to perform controlled acts authorized to Respiratory Therapists via the exception in the *RHPA* provided:

1. they are enrolled in a program to become a Respiratory Therapist, and only perform the authorized acts as part of their educational program;
2. the authorized acts are within the Respiratory Therapy scope of practice; AND
3. they perform these authorized acts under the supervision or direction of a Member of the profession.

- *Treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;* (*RHPA* s.29 (1)c)
- *Treating a member of the person's household and the act is a controlled act set out in paragraph 1, 5 or 6 of subsection 27 (2)* (*RHPA* s.29 (1)d), which are:
  - *Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.* (*RHPA* s.27 (2)1)
  - *Administering a substance by injection or inhalation.* (*RHPA* s.27 (2)5)

- Putting an instrument, hand or finger,
  - beyond the external ear canal,
  - beyond the point in the nasal passages where they normally narrow,
  - beyond the larynx,
  - beyond the opening of the urethra,
  - beyond the labia majora,
  - beyond the anal verge, or
  - into an artificial opening into the body. (*RHPA* s.27 (2)6)

- *assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6 of subsection 27 (2)* (*RHPA* s.29 (1)d), which are:
  - *Administering a substance by injection or inhalation.* (*RHPA* s.27 (2)5)
  - *Putting an instrument, hand or finger,*
    - *beyond the external ear canal,*
    - *beyond the point in the nasal passages where they normally narrow,*
    - *beyond the larynx,*
    - *beyond the opening of the urethra,*
    - *beyond the labia majora,*
    - *beyond the anal verge, or into an artificial opening into the body.* (*RHPA* s.27 (2)6)

Tracheostomy Tube Changes

The authority for RTs to perform tracheostomy tube changes for an established stoma and for a fresh stoma is derived from the *Controlled Acts Regulation* (s.14).

Table 3: Procedures below the Dermis & Tracheostomy Tube Changes

PROCEDURE	RRT	GRT*	PRT
Tracheostomy tubes change for a stoma that is more than 24 hours old.	✓	✓	**
Tracheostomy tubes change for a stoma that is less than 24 hours old.	✓		

* GRTs require general supervision to perform a controlled act and are not permitted to delegate any controlled acts.

** PRTs are only able to perform tracheostomy tubes change for a stoma that is more than 24 hours old if explicitly permitted to do so by the terms and conditions of his/her certificate of registration.

PLEASE NOTE:

Due to the fact that tracheostomy tube changes are now listed as an exemption in the *Controlled Acts regulation*, respiratory therapists (RRTs, GRTs and PRTs) are no longer permitted to delegate tracheostomy tube changes.

PLEASE NOTE:

The timelines regarding tracheostomy tube changes of > and < 24 hours refers to surgical tracheostomies, not Percutaneous Tracheostomies. When changing percutaneous tracheostomy tubes, RTs must ensure they are doing so in accordance with their organizational policy with respect to timelines.

The Forms of Energy section of the *Controlled Acts Regulation* outlines the procedures that fall under the controlled act "application of a form of energy". One of those procedures is the application of soundwaves for diagnostic ultrasound. Diagnostic ultrasound is used to visualize structures (e.g., for procedural guidance) and requires frequencies between 2 and 20MHz .

As of January 1, 2019, RTs who wish to use diagnostic ultrasound in their practice (e.g., radial arterial line catheterization, lung ultrasound) require **both delegation and a valid order** (direct order or medical directive). Information regarding the delegation process can be found in the CRTO's Delegation of Controlled Acts PPG. Information regarding orders can be found in the CRTO's Orders for Medical Care PPG.

Information on ultrasound is available on the CRTO's Diagnostic Ultrasound Communiqué. In addition, the Respiratory Therapy Society of Ontario (RTSO) has assembled resource documents, including templates that can be adapted to local practice settings to assist RTs in establishing the necessary delegation and order processes. This material can be found on the RTSO webpage entitled Point of Care Ultrasound Delegation and Medical Directive Resources for RRTs and RRT/AAs.

Authorizing Mechanisms (Direct Orders and Medical Directives)

Of the five controlled acts authorized to RTs via the *RTA*, three require additional authorizing mechanisms such as direct orders or medical directive.

Table 4: Authorizing Mechanisms

RTA	Direct Order/Medical Directive Required?
#1. Performing a prescribed procedure below the dermis.	Yes
#2. Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx.	Yes
#3. Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx.	No
#4. Administering a substance by injection or inhalation.	Yes
#5. Administering a prescribed substance by inhalation.	No

The *RTA* s 5(1) states RTs are only permitted to accept a direct order/medical directive from one of the following regulated health care professionals:

- *a member of the College of Physicians and Surgeons of Ontario, the College of Midwives of Ontario or the Royal College of Dental Surgeons of Ontario;*
- *a member of the College of Nurses of Ontario who holds an extended certificate of registration under the Nursing Act, 1991; or*
- *a member of a health profession that is prescribed by regulation.*

Additional information on authorizing mechanisms can be found in the CRTO's *Orders for Medical Care PPG*.

Relevant Legislation

It is a standard of practice that RTs practice within the ethical and legislative framework that influences the practice of respiratory therapy. In other words, you must ensure that you satisfy any other legislative requirements regarding the authority to perform controlled acts, authorized acts, and procedures that may be required by your practice setting, for example, the *Public Hospitals Act* or the *Independent Health Facilities Act*.

Employers Requirements

Your employer may have policies related to your authority to perform procedures, including controlled acts, authorized acts, and acts that fall within the public domain. If your employer's policies are more restrictive than the CRTO's requirements— you should abide by your employer's policies. Where your employer's policies are more permissive than the requirements of the CRTO — you must adhere to the requirements of the CRTO.

For clarification about procedures or activities that are not listed in this guideline, please contact the CRTO's Manager of Quality Practice at hamp@crto.on.ca.

Notes:

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:

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

Phone	**416-591-7800**	**Fax**	**416-591-7890**
Toll Free	**1-800-261-0528**	**E-mail**	**questions@crto.on.ca**

Revised Interpretation of Authorized Acts PPG for review.

College of Respiratory Therapists of Ontario

Professional Practice Guideline

Interpretation of Authorized Acts

CRTO publications containing 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. All Members are required to abide by these CRTO publications, and they will be used in determining whether appropriate standards of practice and professional responsibilities have been maintained.

> It is important to note that employers may have policies related to an RT's ability to accept delegation to dispense medications. 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.

March 2020
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.

Table of Contents

Introduction

Scope of Practice of Respiratory Therapy

The scope of practice outlined in the *Respiratory Therapy Act* (*RTA*) states:

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 (*RTA.* s.3)

While the **professional scope of practice**, as defined by the *RTA,* is broad, each RT has their own **personal scope of practice** that is influenced by factors such as their role within their specific practice setting. It is important to remember that having the authority to perform a controlled act does not mean it is appropriate to do so. The CRTO's Standards of Practice states that a Respiratory Therapist must practice within both the professional scope of practice and their personal scope of practice (Standard 4 – Competence/Ongoing Competence)

It is also important to note that not all tasks that might fall under a particular authorized act are within the scope of practice of Respiratory Therapy.

For example…

"*Administering a substance by injection or inhalation*" is a controlled act authorized to RTs. This enables RTs are to administer medications by injection that are within the RT scope of practice (e.g., flu vaccines, procedural sedation, etc.). However, medications such as forms of botulinum toxins (i.e., Botox) are outside of the RT scope of practice. Therefore, to administer those types of substances, a formal delegation process is required.

Controlled Acts, Public Domain & Authorized Acts

Controlled Acts

The *Regulated Health Professions Act* (*RHPA*) identifies fourteen **controlled acts** that pose a significant risk of harm to the public of Ontario [*RHPA* section 27(2)]. These acts may only be performed by regulated health professionals who are authorized by their profession-specific acts (e.g., *Respiratory Therapy Act*).

If that authority has not been granted to an individual via their professional specific legislation, there are two alternative processes by which a controlled act can be performed, which are as follows:

1. **Legislative Exceptions & Exemptions**
   The *RHPA* identifies certain exceptions where an individual may perform controlled acts even if they do not have the necessary authority to do so, and these are outlined in the Exceptions within the RHPA section of this practice guideline. In addition, there are exemptions in other legislation that enables Respiratory Therapists and other healthcare professions to perform other specific tasks. This is outlined in the Exemptions within the Controlled Acts Regulation section of this practice guideline.

2. **Delegation**
   Authority to perform a controlled act may be obtained through the process of delegation from a regulated health professional who has the authority to perform the controlled act to another person (regulated or unregulated), who does not have

this authority. The controlled acts that are not authorized to Respiratory Therapists but that could be delegated are outlined in the Delegation of Controlled Acts Not Authorized to Respiratory Therapists section of this practice guideline.

Public Domain

If a task is not a controlled act, then it is considered to be in the **public domain** and may be performed by anyone (regardless of whether they are a regulated healthcare professional or not), provided they are competent to do so. Regulated health professionals must adhere to the standards of practice of their respective profession while performing activities that fall within the public domain.

Examples of Public Domain tasks…

1. Administering an oral medication;
2. Spirometry (with no bronchodilators)

Controlled Acts Authorized to Respiratory Therapists

The *Respiratory Therapy Act* (RTA) is the profession-specific legislation that lists the five controlled acts authorized to Respiratory Therapists (RTs)* in Ontario. These five controlled acts are referred to as the profession's authorized acts** and are as follows:

1. *Performing a prescribed procedure below the dermis*.
2. *Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx*.
3. *Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx*.
4. *Administering a substance by injection or inhalation.*
5. *Administering a prescribed substance by inhalation*.

*In this practice guideline, "Respiratory Therapists (RTs)" refers to CRTO Members who hold an Active General Certificates of Registration with the CRTO with no terms, conditions or limitations preventing them from performing any authorized acts. Graduate Respiratory Therapists (GRTs) and Practical (Limited) Respiratory Therapists (PRTs) have specific terms, conditions and limitations that are outlined below.

** All five authorized acts may be performed on adult, pediatric and neonatal populations.

Please note…

Authorized Act #4 enables **RRTs, PRTs & GRTs** to perform all procedures that fall under the authorized act *Administering a substance by injection or inhalation*, **provided they have a valid order**.

Authorized Act #5 enables only **RRTs** to administer a substance that is "prescribed" in regulation. In this case, the regulation is the *Prescribed Substance Regulation* and the substance is oxygen. **This authorized act does not have the requirement of an order**. Therefore, an RRT can independently administer oxygen, provided they are not prevented from doing so by any other piece of legislation or polices. More information can be found on this act in the Administering a prescribed substance by inhalation section of this practice guideline.

Authorized Act #1 - *Performing a prescribed procedure below the dermis.*

In this first authorized act, "prescribed" means prescribed in regulation. The *Prescribed Procedures Regulation* lists the specific procedures included under the controlled act of *"performing a prescribed procedure below the dermis"* and separates them into two categories: basic and advanced. Table 1 outlines what procedures are contained within the regulation and provides some examples of specific procedures. Please note that the list of examples is not exhaustive and is offered simply as a point of clarification.

Table 1: Prescribed Procedures below the Dermis

Procedure	Examples
Basic	
i. Arterial, venous, and capillary puncture.	• Arterial Blood Gas.
ii. Insertion, suturing, aspiration, repositioning, manipulation and removal of an arterial cannula.	• Arterial line.
iii. Insertion, suturing, aspiration, repositioning, manipulation, and removal of a venous cannula.	• Peripheral IV • Internal Jugular Vein cannulation
Advanced	
i. Manipulation or repositioning of a cannula balloon.	• Pulmonary Capillary Wedge Pressure (PCWP). • Intra-Aortic Balloon Pump (IABP)
ii. Chest needle insertion, aspiration, reposition, and removal.	
iii. Chest tube insertion, aspiration, reposition and removal.	
iv. Bronchoscopic tissue sample for the purpose of bronchoalveolar lavage and endobronchial brushing.*	
v. Intraosseous needle insertion.	
vi. Subcutaneous electrode placement for interoperation and perinatal fetal monitoring.	

*Tissue biopsy is not included as part of this procedure because it requires the sample to be taken below the mucous membrane, which is not authorized to RTs. To perform a tissue biopsy, delegation is required.

Specific Requirements for Performing Prescribed Procedures below the Dermis

- To perform any procedure classified as Advanced, a Registered Respiratory Therapist (RRT) must have completed a CRTO approved certification/recertification program within the past two years. More information is available in the CRTO's Certification Programs for Advanced Prescribed Procedures below the Dermis PPG.

- Graduate Respiratory Therapists (GRTs) and Practical Respiratory Therapists (PRTs) must not perform any procedure classified as Advanced, even if they have successfully completed an approved certification program.

- PRTs must not perform any procedure classified as Basis unless they have been granted to do so by the CRTO's Registration Committee (i.e., have specific terms and conditions applied to their certificate of Registration).

Table 2: Procedures below the Dermis & Tracheostomy Tube Changes.

Procedure	RRT	GRT*	PRT
Basic prescribed procedures.	✔	✔	**
Advanced prescribed procedures.	✔		

Regional Anesthesia

The insertion of spinal, epidural blocks and peripheral nerve blocks are not authorized under the current *Prescribed Procedures* regulation; therefore, delegation is required. The injection of medication through these routes; however, falls under "*administering a substance by injection or inhalation*", which is authorized to RTs.

Authorized Act #2 - *Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx.*

The second controlled act authorized to RTs is *intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx*. "Beyond the larynx" is interpreted by the CRTO as at or below the level of the larynx, whether you are referring to the airway or the esophagus, including access by oral, nasal, and artificial opening routes.

Examples of tasks an RT can perform under this authorized act are:

- Endotracheal intubation, including nasal and oral routes, as well as bronchoscopic assisted techniques;
- Laryngeal mask insertion;
- Nasogastric tube insertion and the insertion of specially designed nasogastric tubes with EMG electrodes that cross the diaphragm for the purpose of Neurally Adjusted Ventilatory Assist (NAVA);
- Nasal airway insertion; and
- Feeding tube insertion.

Authorized Act #3 - *Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx.*

The third controlled act authorized to RTs is s*uctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx.* Beyond the larynx is interpreted as at or below the level of the larynx, whether you are referring to the airway or the esophagus, including access by oral, nasal, and artificial opening routes.

An RT may perform suctioning via a number of routes, including nasopharyngeal, tracheal, nasogastric, and bronchoscopic. The *RTA* does not require an order for this authorized act; however, other pieces of legislation may have an impact on whether or not an order is required (e.g., *Public Hospitals Act* – Hospital Management Regulation). In addition, an RT must comply with their employer's policies and procedures regarding suctioning.

Authorized Act #4 - *Administering a substance by injection or inhalation.*

The fourth controlled act authorized to RTs is *administering a substance by injection or inhalation.*

1. Under this act, an RT may *administer a substance by inhalation* in the following forms:

    - **Liquids** (e.g., surfactant, epinephrine instillation)
    - **Powders** (e.g., Turbuhaler™, Diskus™)
    - **Aerosols** (e.g., wet nebulization, bronchodilators, narcotics, antibiotics, bronchoprovocators (e.g., Methacholine)
    - **Gases**
        - anesthetic (e.g., Nitrous oxide)
        - non-anesthetic (e.g., Oxygen, Heliox, Nitric Oxide, Compressed Air)
        - specialized (e.g., Carbon Monoxide, Helium, Nitrogen)
        - pressurized (e.g., invasive and non-invasive positive pressure ventilation - including CPAP, BiPAP, Hyperbaric Oxygen Therapy)
    - **Vapors** (e.g., anesthetic agents such as Isoflurane)

2. Under this act, an RT may *administer substances by injection* via the following routes:
    - **Intravascular** –(e.g., Intravenous D5W, Normal Saline, Ringers Lactate, blood products)
    - **Intramuscular** (e.g., Vaccines, Vitamin K, Narcan, Epinephrine)
    - **Intradermal** (e.g., TB test)
    - **Sub-cutaneous** (e.g., Xylocaine, Heparin)

Please note…

Vaccines administered by RTs must only be those recommended in established guidelines (e.g.,ATS, CTS) for the management of cardiorespiratory and associated disorders (e.g., COVID, Influenza, Pneumococcal Pneumonia).

Non-Invasive Positive Pressure Ventilation (NIPPV)

It is the position of the CRTO that air that has been augmented, whether by changing the concentration of the constituent gases (e.g., adding oxygen) or by adjusting the pressure beyond atmospheric, constitutes "*administering a substance by…inhalation*". Therefore, the application of NIPPV is a controlled act and should only be performed by health care professionals who have the statutory authority (4th authorized act in the *Respiratory Therapy Act*) as well as the requisite education, training and clinical competence.

Authorized Act #5 - *Administering a prescribed substance by inhalation.*

The *Prescribed Substances Regulation* currently lists oxygen as the substance that RTs can administer. RRTs, PRTs & GRTs have always been able to - and still are able to - administer oxygen on the order of a physician, midwife, dentist or nurse practitioner. The difference with the 5th authorized act is that, similar to suctioning, it does not have the requirement of an order. This means that RRTs, depending on where they work, can independently initiate, titrate or discontinue oxygen-based solely on their own professional judgment. **Please note that this authorized act only applies to RRTs.**

It is important to understand, however, that there are other pieces of legislation and policies that limit where RTs can independently administer oxygen. The most applicable piece of legislation, in this instance, is the *Public Hospitals Act – Hospital Management Regulation*, which stipulates that every act performed in a public hospital requires an order and limits who can provide those orders. However, this restriction does not apply to non-public hospital/community practice settings (e.g., Home Care, Family Health Teams, private community-based clinics, etc.).
In addition, the Home Oxygen Therapy Policy and Administration Manual (October 2019) currently stipulates that the initiation and discontinuation of oxygen must be ordered by a physician and that any changes to the prescription are the responsibility of the ordering physician.

For more information, please refer to the *Oxygen Therapy* CBPG and the Independent Administration of Oxygen FAQ.

For example…

An RRT working in the community who has been asked to provide oxygen to a patient who is self-paying for the therapy. In this situation, the RRT may initiate, titrate and/or discontinue therapeutic oxygen based solely on their own professional judgement. The RRT must make their own determination on the patient's oxygen settings and set their own fee structure. As with any situation when charging for clinical services, the RRT will need to ensure that:

1. the therapy is clinically indicated;
2. they are not in a conflict of interest;
3. the patient is making a fully informed decision on their course of care; and
4. they are charging a fair and reasonable rate for their services*.

*Currently, RRTs do not have the ability to bill OHIP for services.

Hyperbaric Oxygen Therapy (HBOT)

The 5th authorized act, in combination with the *Prescribed Substances* regulation, permits RTs to independently administer therapeutic oxygen. Therefore, in a hyperbaric clinic located outside of a hospital, RRTs can administer oxygen without the additional requirement of an order from a physician or other authorizer. However, this administration of oxygen must occur in accordance with a diagnosis and prescribed treatment plan (e.g., dive depth/pressure, time, etc.) that has been determined by the most responsible physician. RRTs cannot independently initiate hyperbaric therapy.

In both the hospital and community setting, certification as a Hyperbaric Technologist by the Undersea and Hyperbaric Medical Society (UHMS) sets the industry standard and that any RRT administering HBOT would be expected to perform to. In the *Oxygen Therapy* PPG, the CRTO outlines 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. **Therefore, the CRTO does not endorse "off label" use of HBOT and the engagement of an RT in such activity by an RT may be considered professional misconduct** (*Professional Misconduct Regulation* (s.7) - *Recommending, dispensing or selling medical gases or equipment for an improper purpose*)**.** In addition, the CRTO's Standards of Practice states that *RTs must refrain from making a representation about a remedy, treatment, device or procedure for which there is no generally accepted scientific or empirical basis*. (Standard 8 – Evidence Informed Practice)

Considerations when Performing Authorized Acts

When determining if it is appropriate to perform an authorized act, an RT must first consider the following:

- Is the performance of the authorized act in the best interest of the patient?
- Do they possess the requisite competencies (knowledge, skills & abilities) to perform the authorized act safely?
- Is the performance of this particular task within the Scope of Practice of Respiratory Therapy?
- Does their Certificate of Registration permit them to perform it (i.e., do they hold the appropriate certificate of registration required, and are there any terms, conditions, or limitations on their Certificate of Registration preventing them from performing this task?)
- Is an Authorizing Mechanism (Direct Order or Medical Directive) required to perform this authorized act, and, if so, do they have a valid order (direct order or medical directive) from an authorized prescriber?

Authority & Authorizing Mechanisms

As mentioned at the beginning of this practice guideline, other methods of gaining the authority to perform a controlled act are delegation and exceptions that exist within specific pieces of legislation, such as the *RHPA* and the *Controlled Acts Regulation*.

Delegation of Controlled Acts Not Authorized to Respiratory Therapists

RTs may, in some specific circumstances, receive delegation to perform a controlled act that is not authorized to Respiratory Therapists. This is permitted provided the specific task to be performed falls within the Scope of Practice of Respiratory Therapy. The controlled acts that RTs are permitted to accept delegation are as follows:

- *Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis*. (*RHPA* s.27 (2)1)

- *Putting an instrument, hand or finger,*
    - *beyond the external ear canal,*
    - *beyond the opening of the urethra*
    - *beyond the labia majora,*
    - *beyond the anal verge*
    - *into an artificial opening into the body.* (*RHPA* s.27 (2)6)

- *Applying or ordering the application of a form of energy prescribed by the regulations under the RHPA.** (*RHPA* s.27 (2)7)
  *The Controlled Acts Regulation (Forms of Energy) outlines the specific tasks that fall under this controlled act.

- *Dispensing a drug as defined in the Drug and Pharmacies Regulation Act.** (*RHPA* s.27 (2)8)
  * RTs are not permitted to receive delegation for the other portions of this controlled act, which are *prescribing, selling, or compounding a drug* and *supervising the part of a pharmacy where such drugs are kept*. More information on Dispensing is available in the CRTO's Administering and Dispensing Medications PPG.

- *Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.* (*RHPA* s.27 (2)13)

More information on the delegation process is available in the CRTO's Delegation of Controlled Acts Professional Practice Guideline (PPG).

Exceptions within the *RHPA*

The RHPA contains certain exceptions that enable someone who is not otherwise authorized to perform a controlled act in specific circumstances, provided they have the requisite competence (knowledge, skills, and judgment) to perform the task safely. The exceptions outlined in the RHPA are as follows:

- *Rendering first aid or temporary assistance in an emergency;* (*RHPA* s.29 (1)a)

- *Fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession;* (*RHPA* s.29 (1)b)

Please note…

Student RTs do not require delegation to perform controlled acts. They are permitted to perform controlled acts authorized to Respiratory Therapists via the exception in the *RHPA* provided:

1. they are enrolled in a program to become a Respiratory Therapist, and only perform the authorized acts as part of their educational program;
2. the authorized acts are within the Respiratory Therapy scope of practice; AND
3. they perform these authorized acts under the supervision or direction of a Member of the profession.

- *Treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;* (*RHPA* s.29 (1)c)

- *Treating a member of the person's household and the act is a controlled act set out in paragraph 1, 5 or 6 of subsection 27 (2)* (*RHPA* s.29 (1)d), which are*:*

    - *Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis*. (*RHPA* s.27 (2)1)

    - *Administering a substance by injection or inhalation*. (*RHPA* s.27 (2)5)

    - *Putting an instrument, hand or finger*,
        - *beyond the external ear canal,*
        - *beyond the point in the nasal passages where they normally narrow,*
        - *beyond the larynx,*
        - *beyond the opening of the urethra,*
        - *beyond the labia majora,*
        - *beyond the anal verge, or*
        - *into an artificial opening into the body.* (*RHPA* s.27 (2)6)

- *assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6 of subsection 27 (2)* (*RHPA* s.29 (1)d), which are:

    - *Administering a substance by injection or inhalation*. (*RHPA* s.27 (2)5)

    - *Putting an instrument, hand or finger*,
        - *beyond the external ear canal,*
        - *beyond the point in the nasal passages where they normally narrow,*
        - *beyond the larynx,*
        - *beyond the opening of the urethra,*
        - *beyond the labia majora,*
        - *beyond the anal verge, or into an artificial opening into the body.* (*RHPA* s.27 (2)6)

Exemptions within the *Controlled Acts Regulation*

Tracheostomy Tube Changes

The authority for RTs to perform tracheostomy tube changes for an established stoma and for a fresh stoma is derived from the *Controlled Acts* Regulation (s.14).

Table 3: Procedures below the Dermis & Tracheostomy Tube Changes.

Procedure	RRT	GRT*	PRT
Tracheostomy tubes change for a stoma that is more than 24 hours old.	✔	✔	**
Tracheostomy tubes change for a stoma that is less than 24 hours old.	✔		

* GRTs require general supervision to perform a controlled act and are not permitted to delegate any controlled acts.

** PRTs are only able to perform tracheostomy tubes change for a stoma that is more than 24 hours old if explicitly permitted to do so by the terms and conditions of ~~his/her~~ their certificate of registration, and 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 procedure.

Please note…

Due to the fact that tracheostomy tube changes are now listed as an exemption in the *Controlled Acts* regulation, respiratory therapists (RRTs, GRTs and PRTs) are no longer permitted to delegate tracheostomy tube changes.

Please note…

That the timelines regarding tracheostomy tube changes of > and < 24 hours refers to surgical tracheostomies, not Percutaneous Tracheostomies. When changing percutaneous tracheostomy tubes, RTs must ensure they are doing so in accordance with their organizational policy with respect to timelines.

Applying a Form of Energy

The "application of a form of energy", which is listed as a controlled act in the *RHPA*, is not authorized to Respiratory Therapists under the *Respiratory Therapy Act, 1991*. Two of these procedures outlined under this controlled act, can apply to the practice of Respiratory Therapy, and may be performed under specific circumstances, with the requisite knowledge, skill and competency. These include:

- diagnostic ultrasound

- use of an Automatic External Defibrillator (AED)

Diagnostic Ultrasound

~~The Forms of Energy section of the *Controlled Acts Regulation* outlines the procedures that fall under the controlled act "application of a form of energy". One of those procedures is the application of soundwaves for diagnostic ultrasound~~. Diagnostic ultrasound is classified as an ultrasound that produces an image or other data and is used to visualize structures (e.g., for procedural guidance) and requires frequencies between 2 and 20MHz .

As of January 1, 2019, RTs who wish to use diagnostic ultrasound in their practice (e.g., radial arterial line catheterization, lung ultrasound) require **both delegation and a valid order** (direct order or medical directive). Information regarding the delegation process can be found in the CRTO's Delegation of Controlled Acts PPG. Information regarding orders can be found in the CRTO's Orders for Medical Care PPG.

~~Information on ultrasound is available on the CRTO's Diagnostic Ultrasound Communiqué.~~ In addition, the Respiratory Therapy Society of Ontario (RTSO) has assembled resource documents, including templates that can be adapted to local practice settings to assist RTs in establishing the necessary delegation and order processes. This material can be found on the RTSO webpage entitled ~~Point of Care Ultrasound Delegation and Medical Directive Resources for RRTs and RRT/AAs.~~ Ultrasound for RRTs & RRT/AAs – Respiratory Therapy Society of Ontario (rtso.ca)

AED (New from the position statement on AED's)

The use of an AED can only be performed if authorized by:

- An order *and* delegation, **or**;
- Exercise of the emergency exception in the RHPA.

How to Authorize the Use of an AED

Order and Delegation

The preferred authorization mechanism is the combination of an order and delegation. Under this approach, the **order** serves to authorize the use of the AED (the application of energy) and the **delegation** *transfers* that authority to the RT. Ideally, this is done "in the moment" on a case-by-case basis, although this may not be practical in the urgency associated with the management of a cardiac arrest. As such, it is permissible to use a standing medical directive and delegation that would apply in these scenarios (i.e., an organization-wide medical directive and delegation that allows any RT who has been trained in the use of AEDs to apply them in specified situations, such as a cardiac arrest).

Emergency Exception

There is an emergency provision in the RHPA that allows for an exception to the restriction on controlled acts. This exception assumes that performance of the controlled act in question is not carried out frequently and that it is truly an emergency. Further, it is important to distinguish between an unforeseen emergency and a "regular" emergency. This distinction is recognized in the *Good Samaritan Act, 2001,* which provides immunity from negligence lawsuits for health professionals who provide "emergency health care services or first aid assistance" at a place other than a hospital or health care facility, thereby implying that those are unforeseen emergencies, whereas the work they do IN hospital and health care facilities are "regular" emergencies. The combination of an order and delegation would be the most appropriate approach for managing "regular" emergencies, although clearly not all cardiac arrests are foreseeable. Therefore, it is acceptable for an RT to apply an AED under the emergency exception, yet ***only*** in circumstances where an order and delegation are not available.

Authorizing Mechanisms (Direct Orders and Medical Directives)

Of the five controlled acts authorized to RTs via the *RTA*, three require additional authorizing mechanisms such as direct orders or medical directive.

Table 4: Authorizing Mechanisms

RTA	Direct Order/Medical Directive Required?
#1. Performing a prescribed procedure below the dermis.	Yes
#2. Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx.	Yes
#3. Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx.	No
#4. Administering a substance by injection or inhalation.	Yes
#5. Administering a prescribed substance by inhalation.	No

The *RTA* s 5(1) states RTs are only permitted to accept a direct order/medical directive from one of the following regulated health care professionals:

- *a member of the College of Physicians and Surgeons of Ontario, the College of Midwives of Ontario or the Royal College of Dental Surgeons of Ontario;*
- *a member of the College of Nurses of Ontario who holds an extended certificate of registration under the Nursing Act, 1991; or*
- *a member of a health profession that is prescribed by regulation.*

Additional information on authorizing mechanisms can be found in the CRTO's *Orders for Medical Care* PPG.

Other Considerations

Relevant Legislation

It is a standard of practice that RTs practice within the ethical and legislative framework that influences the practice of respiratory therapy. In other words, you must ensure that you satisfy any other legislative requirements regarding the authority to perform controlled acts, authorized acts, and procedures that may be required by your practice setting, for example, the *Public Hospitals Act* or the *Independent Health Facilities Act*.

~~Employers Requirements~~ (Removed stated at beginning of PPG)

~~Your employer may have policies related to your authority to perform procedures, including controlled acts, authorized acts, and acts that fall within the public domain. If your employer's policies are more restrictive than the CRTO's requirements — you should abide by your employer's policies. Where your employer's policies are more permissive than the requirements of the CRTO — you must adhere to the requirements of the CRTO.~~

For clarification about procedures or activities that are not listed in this guideline, please contact the CRTO's Coordinator of Quality Practice at arndt@crto.on.ca.

AGENDA ITEM # 5.0

Motion Title:	*Consent Agenda Items*
Date of Meeting:	*September 24, 2021*

It is moved by _____ and seconded by _____ that:

The Council approves the items outlined in the consent agenda, which include in their entirety:

- The minutes from the Council meetings held May 28, 2021 (Item 5.1)
- Executive Committee Report (Item 5.2)
- Registration Committee Report (Item 5.3)
- Quality Assurance Committee Report (Item 5.4)
- Patient Relations Committee (Item 5.5)
- Inquiries, Complaints and Reports Committee Report (Item 5.6)
- Discipline Committee Report (Item 5.7)
- Fitness to Practise Committee Report (Item 5.8)

Agenda Item #:	*5.1*
Item:	*Draft Minutes from May 28, 2021*

Meeting Minutes May 28, 2021

CRTO Council Meeting Minutes

Scheduled on May 28, 2021 from 10:00 am to 1:15 pm

Location: Virtual meeting via Zoom Videoconference

PRESENT:	Allison Chadwick, RRT, President, Chair	Lindsay Martinek, RRT
	Rhonda Contant, RRT, Vice-Chair	Andriy Kolos, Public Member
	Jeff Earnshaw, RRT	Jeff Dionne, RRT
	Kim Morrison, Public Member	Kelly Munoz, RRT
	Katherine Lalonde, RRT	Brad Bedford, Public Member
	Jeffrey Schiller, Public Member	
STAFF:	Carole Hamp RRT, Acting Registrar	Lisa Ng, Manager of Registration
	Janice Carson, Manager of Communications	Denise Steele, Coordinator of Professional Programs
	Kelly Arndt RRT, Coordinator of Quality Practice	Temeka Tadesse, IT & Database Specialist
	Shaf Rahman, Manager of Professional Conduct	Amelia Ma, Finance and Office Manager
	Sophia Rose, Coordinator of Professional Conduct	
GUESTS:	Michelle Causton, fIndependent Chair	Lanjun Wang, CPA, CA, Auditor
REGRETS:	Kevin Taylor, RRT, Registrar & CEO	
	Yvette Wong, Public Member	
	Jody Saarvala, RRT	

1.0: INTRODUCTION AND GUESTS

The meeting was called to order at 10:00am. President Allison Chadwick welcomed Council, Guest and Staff to the meeting.

2.0: APPROVAL OF COUNCIL AGENDA

Council reviewed the agenda for May 28, 2021.

MOTION # 1 MOVED BY Lindsay Martinek, RRT, and SECONDED BY, Kim Morris, to recommend that Council approve the Meeting Agenda for May 28, 2021.

MOTION # 1 CARRIED.

3.0: STRATEGIC ISSUES

3.1 FINANCIAL AUDIT 2019 - 2020

(Guest: Lanjun Wang, CPA, CA, Auditor)

The CRTO's audit provided an overview of the College of Respiratory Therapists of Ontario's draft audited financial statements and explained some of the processes involved with the CRTO's financial audit.

Motion # 2 MOVED BY Lindsay Martinek, RRT, and SECONDED BY Katherine Lalonde, RRT, that Council approve the Audited Financial Statements for 2021.

MOTION #2 CARRIED.

3.2 APPOINTMENT OF AUDITOR FOR 2021-2022

It was determined that the CRTO re-appoint Hilborn LLP as the auditor for 2021-2022 and re-vist the appointment next year.

Motion # 3 MOVED BY Kelly Munoz, RRT, and SECONDED BY Jeffrey Schiller, that Council re-appoints Hilborn, LLP as the CRTO's external auditor for 2021-2022.

MOTION #3 CARRIED.

3.3 ANNUAL REPORT 2020-2021

Janice Carson, Manager of Communications presented to Council the draft 2020-2021 Annual Report. Council was pleased with the overall look of the report and no further changes were suggested.

Motion # 4 MOVED BY Lindsay Martinek, RRT, and SECONDED BY Rhonda Contant, RRT, that Council approve the draft Annual Report for 2020-2021.

MOTION #4 CARRIED.

4.0: OPERATIONAL & ADMINISTRATIVE ISSUES

4.1 REGISTRAR + STAFF ACTIVITY REPORT

Carole Hamp, Acting Registrar, reported on general CRTO activities and initiatives.

Key Initiatives:

- The CRTO continues to monitor daily stakeholder updates by the Ministry of Health (MOH) Emergency Operations Centre (EOC) and the Critical Care Secretariat of Ontario (CCSO). The role of the CRTO is to be prepared to review our standards and licensing practices in the event of a surge due to the COVID-19 pandemic. The CRTO continues to update the membership on information relevant to RTs in Ontario.
- The MOH requested that RTs from other Canadian jurisdictions come to Ontario to help during the 3rd wave of the pandemic. The Out-of-Province Applicant section to our policy was expanded to permit individuals to begin working with limited delays.
- On April 17, 2021, Council approved the reactivation of the CRTO's Emergency Registration Policy. This policy enables the CRTO to wave Application Fees, defer Registration Fees for up to six months and permits the Registrar to apply terms, conditions, and limitations on a certificate of registration with a 2-to-5-year currency gap (as per the Registration Currency Policy).
- In the Spring of 2021, CRTO established a Policy Framework, as a result, CRTO staff continue to work through a process of refreshing and revising public facing policies and other related documents in a phased approach.
- The elections will be held in the fall with a number of seats available. In Districts 1 there will be 1 Council and 2 Non-Council seats, District 2 will have 1 Council and 2 Non-Council seats, District 5 will have 2 Council and 2 Non-Council seats and District 7 will have 1 Council seat.

4.2 FINANCIAL STATEMENTS

Council reviewed the financial statements as of April 30, 2021.

4.3 INVESTMENT PORTFOLIO

Council reviewed the Investment Portfolio as of April 30, 2021.

4.4 MEMBERSHIP STATISITCS

Lisa Ng, Manager of Registration presented to Council the membership statistics. The total

membership reported was **3,815**. The CRTO received **362** applications for registration from March 1, 2020, to May 7, 2021. Out of the total number of applications received, **313** are graduates of an Ontario RT program, **30** are graduates from other provinces, and **19** are graduates from outside of Canada.

4.5 REVISED COMMITMENT TO ETHICAL PRACTICE PPG – FINAL APPROVAL

Kelly Arndt, Coordinator of Quality Practice presented to Council the final A Commitment to Ethical Practice Professional Practice Guideline (PPG). The PPG provides guidance for ethical decisions and sets the expectations for ethical and moral behaviour. The PPG was last reviewed in 2015, and a revised draft was approved by Council on March 5, 2021. The draft was circulated to the CTRO membership and stakeholders for consultation. CRTO staff revised and made amendments for Council 's consideration.

Motion # 5 MOVED BY Rhonda Contant, RRT, and SECONDED BY Jeff Earnshaw, RRT, that Council approve the final draft of A Commitment to Ethical Practice Professional Practice Guideline.

MOTION # 5 CARRIED.

4.6 USE OF SOCIAL MEDIA BY RTS PPG – DRAFT FOR STAKEHOLDER FEEDBACK

Kelly Arndt, Coordinator of Quality Practice presented to Council The Use of Social Media by RTs Professional Practice Guideline (PPG). The draft document was presented to Council on March 5, 2021 and was approved for circulation to the CTRO membership and stakeholders. Based on the feedback received, revisions were made. CRTO staff received consultation regarding the contents of the document, and in keeping with the Policy Framework, it was decided that this document is better suited as Fact Sheet.

4.7 OFFICE OF THE FAIRNESS COMMISSIONER – SUBMISSION 2020/2021

Lisa Ng, Manager of Registration presented to Council the Fairness Commissioners Report submission for 2020 – 2021. The Office of The Fairness Commissioner assesses the registration practices of regulated professions to make sure they are transparent, objective, impartial and fair for anyone applying to practise in Ontario.

5.0: CONSENT AGENDA ITEMS

5.1 MINUTES FROM MARCH 5, 2021, APRIL 17, 2021 & MAY 1, 2021

Council reviewed the Minutes from March 5, 2021, April 17, 2021, and May 1, 2021. No

changes were made to the minutes.

5.2 EXECUTIVE COMMITTEE REPORT

(Submitted by Allison Chadwick, RRT, Chair)

The Executive Committee has met two (2) times since the March 5, 2021, Council meeting.

Highlights of the Executive Committee's activities are outlined below.

The Executive Committee:

- Appointed Carole Hamp as Acting Registrar during Kevin Taylor's temporary medical leave of absence.
- Reviewed all financial and investment statements for this period.
- Received a presentation from Lanjun Wang (Hilborn LLP) on the 2020-2021 audit.
- Conducted an assessment of the External Auditor.
- Developed a draft agenda for the May 28, 2021, Council meeting.

5.3 REGISTRATION COMMITTEE REPORT

(Submitted by Christa Krause, RRT, Chair)

Since the last Council meeting on March 5, 2021, the Registration Committee met via video conference on the following dates:

- March 3, 2021 – Registration Committee Orientation
- March 30, 2021 – Panel Meeting
- April 15, 2021 – Panel Meeting

Referral Summary

Reason for Referral	Decision
Four applications were referred due to currency requirements.	One application was reviewed on March 30, 2021, the Panel decided to issue a General Certificate of Registration with terms, conditions, and limitations (including general supervision requirements). Three applications were reviewed on April 15, 2021, in one of the applications, the panel decided to issue a General Certificate of Registration with terms, conditions, and limitations (including general supervision requirements). In two of the applications, the

	panel decided to issue a General Certificate of Registration with terms, conditions, and limitations (including direct supervision requirements).
Three applications were referred for a request to change the terms, conditions and limitations imposed on a General Certificate of Registration.	Two applications were reviewed on March 30, 2021, the Panel decided to approve the Members' request to change the terms, conditions and limitations currently imposed on their General Certificates of Registration. One application was reviewed on April 15, 2021, the panel decided to refuse to vary the terms, conditions and limitations currently imposed on the Member's General Certificate of Registration. The Member did not demonstrate that they had acquired the competency and skills to perform administering inhaled medications and administering a prescribed substance by inhalation without supervision.

On March 3, 2021, Richard Steinecke provided the Registration Committee another in-depth orientation and training on the use of precedents, special considerations and issues related to human rights, biases, and anti-discrimination.

On April 17, 2021, with the approval of the Registration Committee, the CRTO Council approved its Emergency Registration Policy re-enactment. This enables the following:

- Waving of application fee
- Deferral of the registration fee for up to 6 months, and
- Streamlining the registration process for the following applicants who wish to register temporarily to assist during the pandemic:
    - Recently resigned members
    - Inactive members
    - Respiratory Therapists registered in another province.

On May 1, 2021, an amendment to the Supervision Policy was forwarded to Council for its review and approval. An amendment was made to add the following:

*in emergency situations (e.g., pandemics) "personally present" includes by remote/virtual connection.

The revised policy enables Respiratory Therapists with general supervision requirements on

their certificate of registration to be supervised remotely/virtually in emergency situations (e.g., pandemics).

5.4 QUALITY ASSURANCE COMMITTEE REPORT

(Submitted by Rhonda Contant, RRT, Chair)

Since the last Council meeting, there has been one meeting of the Quality Assurance Committee (QAC), on March 17, 2021. The following is a summary of that meeting and the activities related to the QAC that have been ongoing since our last Council meeting:

QAC Goals and Terms of Reference

The committee is revising the template for these documents. The Professional Development Program, Launch Jurisprudence, Deferral and Peer Assessor policies have been updated and were brought to the committee for review.

2021 RelevanT elearning Module

The 2021 RelevanT elearning module was developed on the new PDKeepr platform and was due to be completed by February 28, 2021. As of the date of this report, 3467 CRTO Members have completed the RelevanT module. The RelevanT survey results were shared with the committee, with 95% completion by Members. 98% reported that the new module was easy to use. 96% reported that this module increased their understanding of CRTO guidelines and practice standards.

2021 PORTfolio Submissions

819 Members are currently assigned to submit their PORTfolio in 2021. Due to the ongoing pandemic, the deadline has again been extended to June 1st. In addition, the CRTO has notified these Members that if they do not submit their PORTfolio by the extended deadline, they will automatically be deferred to 2022. The orientation for our 43 Peer Assessors has begun.

2021 Launch RT Jurisprudence Assessment

The 2021 Launch RT Jurisprudence Assessment has been moved to the new PDKeepr platform, with 13 new Members completing since the previous report.

Referral to the CRTO Entry to Practice Assessment Process UPDATE

The CRTO recently registered a member who had initially graduated from a United States RT program and applied to become an RT in Ontario in September 2019. At that time, because they did not graduate from an accredited program, they were referred to the IEHP assessment. They completed the Program Review and Behavioral Descriptive Interview before withdrawing from the assessment process and becoming registered with the College and Association of Respiratory Therapists of Alberta (CARTA). Shortly after becoming registered in Alberta, they applied to and was registered with the CRTO. At this point, they

were referred to a panel of the QAC. At the February 4th meeting, the QAC panel determined that the Member should undergo the final phase of the ETP Assessment, the Clinical Skills Assessment ASAP, and as a result, the Member underwent the CSA April 7, 2021.

5.5 PATIENT RELATIONS COMMITTEE REPORT

(Submitted by Michelle Causton, Chair)

Since the last Council meeting, the Patient Relations Committee (PRC) has met once via a Zoom meeting on April 19, 2021. The following is an overview of the key issues that were discussed at that time:

CRTO Sexual Abuse Program Policies
The committee reviewed the policies related to the sexual abuse program. Both the Funding for Supportive Measures (Patient/Client) policy and the Funding for Supportive Measures (Non-Patient/Client) policy were reviewed, there were no changes required.

Abuse Awareness & Prevention PPG
The committee reviewed the Abuse Awareness & Prevention PPG, there are no changes required at this time.

Sexual Abuse Training
The committee reviewed the Health Profession Regulators of Ontario (HPRO) video *Understanding and Managing Our Own Values, Beliefs, Feelings, and Response to Sexual Abuse* to meet the committee's sexual abuse training requirement. The committee is recommending that the video be used not just for PRC but also for Council / Non-Council and as an on-boarding tool for new Council/Non-Council members.

A Commitment to Ethical Practice
The committee reviewed the Commitment to Ethical Practice document and provided feedback to staff on some suggested changes.

Use of Social Media by Respiratory Therapists PPG
The committee reviewed the Use of Social Media by Respiratory Therapists PPG and provided feedback to staff on some suggested changes.

5.6 INQUIRES, COMPLAINTS AND REPORTS COMMITTEE (ICRC)

(Submitted by Jeff Earnshaw, RRT, Chair)

ICRC Deliberations:
Since the last Council meeting, the ICRC held five meetings via Zoom. Three of the meetings were to render decisions on investigations, while the remaining two meetings were to

discuss taking interim action on a member while the investigation into the Member's conducted continued.

Of the three meetings that took place to discuss and render decisions on investigations, one related to an employer report, and the remaining two related to three public complaints.

Employer Report:

1.) The Employer Report alleged that the Member was suspended and asked to engage in mandatory reflective practice stemming from incidents in which it was alleged that the Member had made unprofessional, rude, and homophobic comments towards a colleague. The Panel of the ICRC conducted a very detailed and lengthy consideration of this matter, and decided to provide the Member with a written warning and ordered the Member to complete an essay in which the Member will address the following points:
   - Recognizing the elements of professional communication with the healthcare team and its relevance to patient care.
   - Why the allegation against the Member may represent breaches of professional communication, according to CRTO's Standards of Practice and legislation related to conduct, professionalism, and communication.
   - What the Member will do to ensure that similar incidents do not reoccur.

   The Panel conclude that the information before it indicated that the Member engaged in rude and unprofessional behaviour, however, there was no information before the Panel to suggest that the Member made homophobic comments.

Public Complaints:

2.) The complaint alleged that the Member denied services to the client by refusing to exchange the client's CPAP machine, and that the Member was rude and unprofessional to the client. After a careful review of the information in the investigation report and submissions by both the Complainant and Member, a Panel of the ICRC took no action regarding the concerns brought forward.

   The Panel was of the opinion that the Member met the standards of practice by attempting to fix the client's CPAP machine, which would have been required prior to obtaining a replacement machine through the manufacturer. Further, the Panel was of the opinion that the Member acted professionally throughout the interactions with the client.

3.) The complaint alleged that the Member, during a home visit, did not elevate their concern level and did not advocate for the patient to be taken to hospital. The

patient was then taken to hospital two days later. After considering the investigation report into the allegations and the submissions by the Complainant and Member, a Panel of the ICRC took no action regarding the concerns raised.

The Panel was of the opinion that the Member met the standards of practice in regard to their assessment of the patient during the home visit. The vitals taken of the patient indicated that there was no clinical need to take the patient to the hospital. It appeared to the Panel that the patient's condition started to deteriorate the following day. Further, the Member provided appropriate direction to the patient's family if the patient's condition were to worsen.

4.) The complaint alleged that the Member had provided inadequate training to a nurse, who was then assigned to the patient's home. During an evening shift by the nurse at the patient's home, the patient's condition deteriorated, and the patient passed away. After considering the information contained in the investigation report and the submissions made by the Complainant and Member, a Panel of the ICRC took no action regarding the concerns raised.

The Panel was of the opinion that the Member had done their due diligence in obtaining the nurse's prior training history and provided appropriate training and directions to the nurse. The nurse was also offered additional training and observation of client interventions, but declined the offer. The Panel did not comment on the appropriateness of the nurse's interventions during the evening the patient passed away, as it was not within their jurisdiction to do so.

Interim Action:

5.) An employer report was received in which it was alleged that the Member lacked core competencies of the profession. A Panel of the ICRC approved an appointment of investigator to investigate the matter. Further, based on the information in the employer report, the Panel was concerned that the Member's alleged lack of competency may place the Member's current patients at risk of harm. As such, the Panel formalized their intent to place interim terms, conditions, or limitations (TCLs) on the Member's certificate of registration and invited the Member to provide submissions.

The Panel reconvened to discuss and finalize their intent to place an interim TCL once the Member had provided their response. After careful review of the Member's response, the Panel concluded that more information was required. As such, the Panel directed staff to obtain more information from the Facility prior to confirming their intent to place TCLs.

New Matters:
Since the last Council meeting, the CRTO received seven new matters, three of which were Employer Reports and four were anonymous reports made by members of the public. Of the three employer reports, one is currently under investigation. The second report was determined to not warrant an investigation, as during the inquiry stage, the Registrar did not have reasonable and probable grounds to believe that the Member had committed an act of professional misconduct or was incompetent. The third report is currently in the inquiry stage.

Of the four anonymous reports, one is currently under investigation, while three remain at the inquiry stage.

5.7 DISCIPLINE COMMITTEE
(Submitted by Lindsay Martinek, RRT, Chair)

Since the last Council meeting there have been no Discipline hearings, nor referrals to the Discipline Committee.

5.8 FITNESS TO PRACTISE COMMITTEE
(Submitted by Lindsay Martinek, RRT, Chair)

Since the last Council meeting there have been no new referrals to the Fitness to Practise Committee and no Fitness to Practise hearings have taken place.

Motion # 6 MOVED BY Kelly Munoz, RRT, and SECONDED BY Katherine Lalonde, RRT, to recommend that Council approve all consent agenda items.

MOTION # 6 CARRIED.

6.0: COMMITTEE ITEMS ARISING

6.1 EXECUTIVE COMMITTEE ITEMS

6.1.1 RATIFY EXECUTIVE'S APPOINTMENT OF AN ACTING REGISTRAR

Kevin Taylor, the current CRTO CEO & Registrar was required to take a medical leave from his duties effective April 14, 2021.

S.5.01 of the CRTO By-Laws (25 – 2019) states that "A person who has been appointed by the Council as Acting Registrar during the prolonged absence or disability of the Registrar, shall discharge all the duties of the Registrar."

S21.02 of the B-Laws also states that "As set out in the RHPA, the Executive Committee has, between Council meetings, all the powers of Council with respect to any matter that, in the Committee's opinion, requires immediate attention, other than the power to make or amend the By-Law, or revoke a Regulation."

Advice from our legal counsel, Julie Maciura was that Council should ratify the appointment by Executive at the next Council meeting.

6.1.2 IN CAMERA SESSION REGISTRAR SALARY

The discussion of the Acting Registrar salary compensation was in camera in accordance with the *Regulated Health Professions Act*, 1991, Health Professions Procedural Code Section (2) where (d) personnel matters or property acquisitions are discussed.

Motion # 7 MOVED BY Rhonda Contant, RRT, and SECONDED BY Jeff Dionne, RRT, to recommend that Council approve the ratification of Carole Hamp's appointment to Acting Registrar.

MOTION #7 CARRIED.

6.2 REGISTRATION COMMITTEE ITEMS

- No items for this meeting.

6.3 QUALITY ASSURANCE COMMITTEE ITEMS

6.3.1 REVISED QAC GOALS & TERMS OF REFERENCE

Rhonda Contant, RRT, presented to Council the revised QAC Goals and Terms of Reference. The Quality Assurance Committee met on March 17, 2021, the members reviewed the Goals and Terms of Reference document. It was recommended at that time to revise the document into the new Terms of Reference and Action Plan. The QAC members felt it was important to have consistency across the CRTO committees and adapted the document,

with permission, from the Patient Relations Committee. The new document was drafted by CRTO staff and was approved by the QAC on April 27, 2021.

Motion # 8 MOVED BY Rhonda Contant, RRT, and SECONDED BY Allison Chadwick, RRT, to recommend that Council approve the new Quality Assurance Committee Terms of Reference and Action Plan.

MOTION #8 CARRIED.

6.4 PATIENT RELATIONS COMMITTEE ITEMS

- No items for this meeting.

6.5 INQUIRES COMPLAINTS AND REPORTS COMMITTEE ITEMS

- No items for this meeting.

6.6 DISCIPLINE & FITNESS TO PRACTISE COMMITTEES ITEMS

- No items for this meeting.

7.0: LEGISLATIVE AND POLICY ISSUES:

7.1 OVERVIEW OF NEW POLICY FRAMEWORK

Carole Hamp, Acting Registrar presented to Council an overview of the new Policy Framework which was established in the Spring of 2021. As a part of the CRTO mandate to regulate and govern the practice of Respiratory Therapy, the College of Respiratory Therapists of Ontario (CRTO) develops and maintains a set of policies, fact sheets, and other regulatory documents. As the CRTO continues to adapt and evolve, a Policy Framework has been developed that will classify its regulatory documents into clear definitions and help guide the CRTO's processes for establishing and revising these documents.
The goals of the Policy Framework are to:

- Enable operational processes that are public-focused, transparent, objective, and adaptive;
- Build on best practice examples from other health regulators; and
- Support CRTO in meeting the standards and measures outlined in the ministry's College Performance Measurement Framework.

7.2 REVISED ACCESSIBILITY STANDARDS POLICY

Janice Carson, Manager of Communications presented to Council the Revised Accessibility Standard Policy. This document was originally approved by Council on April 30, 2012, and last revised on August 22, 2018. As part of the Policy Framework this policy was updated in the new template, the intent and direction of the policy remained, and a procedure was created. This policy was posted for public consultation on the CRTO website and on the Ontario Health Regulators website.

Motion # 9 MOVED BY Allison Chadwick, RRT, and SECONDED BY Kim Morris, to recommend that Council approve the Accessibility Standards Policy (AD-205)

MOTION #9 CARRIED.

7.3 REINSTATEMENT OF FORMER MEMBERS FOUND GUILTY OF SEXUAL ABUSE - POLICY TO FACT SHEET

Sophia Rose, Coordinator of Professional Conduct presented to Council the Reinstatement of Former Members Found Guilty of Sexual Abuse – Policy to Fact Sheet document. The document was originally approved by Council on February 26, 1999, and last revised on June 13, 2003, therefore recent review and revision was required. It was proposed that Council rescind and archive this policy, as Reinstatement of Former Members Found Guilty of Sexual Abuse is stated in the Code therefore the policy is not needed. This information will remain available to members of the public and CRTO members on the CRTO website, as a Fact Sheet.

Motion # 10 MOVED BY Allison Chadwick, RRT, and SECONDED BY Rhonda Contant, RRT, to recommend that Council rescind and archive the policy Reinstatement of Former Members Found Guilty of Sexual Abuse and replace with a Fact Sheet.

MOTION #10 CARRIED.

8.0: OTHER BUSINESS

- No items for this meeting.

9.0: NEXT MEETING

Next Council Meeting:
Friday, September 24, 2021, from 09:00 to 12:00 hrs.

Location:
Virtual meeting held via ZOOM Videoconference.

10: ADJOURNMENT

Adjournment

MOTION # 11 MOVED BY Allison Chadwick, RRT, and SECONDED BY Rhonda Contant, RRT to adjourn the Council Meeting.

MOTION # 11 CARRIED.

The May 28, 2021, Council Meeting adjourned at 1:15 pm.

Agenda Item #:	*5.2*
Item:	*Executive Committee Report*

EXECUTIVE COMMITTEE REPORT – CHAIR'S REPORT TO COUNCIL

May 28, 2021 to September 23, 2021

The Executive Committee has met once since the May 28th Council meeting.
Highlights of the Executive Committee's activities are outlined below.

At the September 14th meeting, the Executive Committee:

- Reviewed all financial and investment statements for March 1 – August 31, 2021.
- Developed a proposal for Council regarding the Registrar & CEO position.
- Approved the draft agenda for the September 24th Council meeting.
- Reviewed and revised the Executive Goals & Terms of Reference.
- Discussed the upcoming Executive Committee elections.
- Approved the 2022 Council dates.
- Reviewed draft versions of the revised Investments and Reserves Policy & Procedure.

Respectfully submitted,
Allison Chadwick, RRT
Executive Committee Chair

Agenda Item #:	*5.3*
Item:	*Registration Committee Report*

REGISTRATION COMMITTEE REPORT – CHAIR'S REPORT TO COUNCIL

May 28, 2021 to September 23, 2021

Since the last Council meeting on May 28, 2021, the Registration Committee met via video conference on the following dates for four separate panel meetings:

- June 8, 2021
- June 24, 2021
- July 19, 2021
- August 25, 2021

Referral Summary

Reason for Referral	Decision
One application requesting to change the terms, conditions and limitations imposed on the member's certificate of registration.	The request was approved. The panel agreed to change the terms, conditions, and limitations to allow the member to perform specific procedures without supervision.
Two applications were referred to consider whether it is in the public interest to approve the applications based on the applicants' entry-to-practice assessment results. Both applicants had completed all three stages of the assessment.	In both cases, the decisions were to refuse to issue a certificate of registration. In one of the cases, the panel recommends the applicant complete an approved respiratory therapy program before reapplying. In the second case, the panel recommends the applicant to successfully complete the Canadian Board for Respiratory Care exam, and then reapply for registration. In addition, the applicant should also provide proof of upgrading/training.

Certificate Programs for Prescribed Procedures Below the Dermis

At the July 19, 2021, videoconference meeting, a panel of the Registration Committee reviewed and subsequently approved two certification packages prepared by the Children's

Hospital of Eastern Ontario (CHEO).

1. Certification package for Chest Needle Insertion, Care and Removal.
2. Certification package for Intraosseous Needle Insertion.

Entry-to-Practice Exam Policy
Following the new CRTO's framework, the Entry-to-Practice Exam Policy and Procedure was revised. This policy was last reviewed on December 3, 2010, by Council. Due to the new policy framework, this policy was updated in the new template and its associated procedure and factsheet (Examination). Although the policy was revised, its intent and direction have not changed.

The Entry-to-Practice Exam Policy was circulated to the Registration Committee for consultation. On September 10, 2021, the Registration Committee motioned to have the revised Entry-to-Practice Exam Policy go to Council for approval.

Respectfully submitted,
Christa Krause, RRT
Registration Committee Chair

Agenda Item #:	*5.4*
Item:	*Quality Assurance Committee Report*

QUALITY ASSURANCE COMMITTEE REPORT – CHAIR'S REPORT TO COUNCIL

May 28, 2021 to September 23, 2021

Since the last Council meeting, there has been two panel meetings of the Quality Assurance Committee (QAC), on May 25 and June 28, 2021. The following is a summary of those meetings and the activities related to the QAC that have been ongoing since our last Council meeting:

Professional Development Policy and Procedure (PDP) Revision
Following the new CRTO framework, the Professional Development Program policy and procedure was revised, incorporating the previously separate Launch Jurisprudence Assessment policy.

2021 PORTfolio Submissions
819 Members were assigned to submit their PORTfolio in 2021. Submission deadline was June 1, 2021. 622 Portfolios were received and reviewed. The remaining were considered to be automatically deferred until 2022. Subsequently, 22 were required to undergo peer coaching, and all were successful in completing those Portfolio requirements.

Referral to the CRTO Entry to Practice Assessment Process UPDATE
The CRTO recently registered a Member who had initially graduated from a U.S RT program and applied to become an RT in Ontario in Sept. 2019. At that time, because he did not graduate from an accredited program, he was referred to the IEHP assessment. He completed the Program Review and Behavioral Descriptive Interview before withdrawing from the assessment process and becoming registered with the College and Association of Respiratory Therapists of Alberta (CARTA). Shortly after becoming registered in Alberta, he applied to and was registered with the CRTO. At this point, he was referred to a panel of the QAC.

At the February 4th meeting, the QAC panel determined that the Member should undergo the final phase of the ETP Assessment, the Clinical Skills Assessment ASAP, and as a result, the Member underwent the CSA April 7, 2021. A QAC panel met on May 25, 2021 to review the results of the CSA and a decision was made to direct the Registrar to impose terms, conditions and limitations on the Members General Certificate of Registration, and require the Member to undergo remediation in the form of education and online modules. The Member subsequently appealed this decision on June 24, 2021. The panel met again on June 28, 2021 to review the appeal, however the initial decision was upheld.

Respectfully submitted,
Rhonda Contant, RRT
Quality Assurance Committee Chair

Agenda Item #:	*5.5*
Item:	*Patient Relations Committee Report*

PATIENT RELATIONS COMMITTEE REPORT – CHAIR'S REPORT TO COUNCIL

May 28, 2021 to September 23, 2021

The Patient Relations Committee has had no meetings since the last Council meeting on May 28, 2021. The next PRC meeting will be held in the fall but is currently unscheduled.

Respectfully submitted,
Michelle Causton, Public Member
Patient Relations Committee Chair

Agenda Item #:	*5.6*
Item:	*Inquiries, Complaints and Reports Committee Report*

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE REPORT – CHAIR'S REPORT TO COUNCIL

May 28, 2021 to September 23, 2021

ICRC Deliberations:
Since the last Council meeting, the ICRC held 2 meetings via Zoom. Both meetings were to render decisions on investigations, one stemming from a Complaint and one stemming from an Employer Report.

Employer Report:

1) The Employer Report alleged that the Member was terminated from her position at the Facility after the Facility determined that the Member had unilaterally managed funds provided through a community grant. The Facility alleged that the Member did not establish appropriate oversight for the grant's distribution, that the Member paid themselves through the grant without appropriate oversight, and that the Member charged the grant for services that were within the scope of their position with the Facility.

   The Panel of the ICRC conducted a very detailed and lengthy consideration of this matter, including seeking a legal opinion on the viability of referring the matter to the Discipline Committee of the CRTO. Base on the legal opinion obtained, the Panel ordered the Member to complete a specified continuing education or remediation program ("SCERP") related to ethics and professionalism known as the "Professional/Problem Based Ethics" program (also known as "ProBE") offered by the Center for Personalized Education for Physicians. Further, the Member is to attend before the Panel to be cautioned.

   The Panel conclude that the information before it indicated that the Member was not forthcoming with the Facility regarding the management of funds, the Member's documentation regarding care provided through the grant and its disbursement was vague and at times misleading, and that the Member did not take any accountability for their actions. The Panel noted that it did not appear to the Panel that the Member did these things intentionally, but the Member's actions did not meet the standards of practice.

Public Complaint:

2) The complaint alleged that the Member failed to provide appropriate level of care to the patient, did not follow the wishes of the patient's power of attorneys, and that the Member was rude and unprofessional.

   After a careful review of the investigation report, Complainant's submissions, and those of the Member; the Panel was of the opinion that the Member met the standards of practice in providing appropriate levels of care to the patient. However, it was clear to the Panel from the information before them that a breakdown occurred in the therapeutic communication between the Member and the patient's family and that the Member appeared to not have met the standards of practice in relation to therapeutic communication. Further, the Panel was concerned that the Member did not document their conversations with the patient's family, as required. Accordingly, the Panel dispensed a letter of warning to the Member which included guidance on how to better meet the standards of practice regarding therapeutic communication.

New Matters:
Since the last Council meeting, the CRTO received 8 new matters. Of the 8 new matters, 2 were Complaints from the public, while the remaining 6 matters were Employer Reports. Of the 6 Employer Reports, 1 of the Employer Reports included concerns regarding 5 respiratory therapists.

Both Complaints received by the CRTO are currently being investigated. 2 of the Employer Reports are currently being investigated.

Of the remaining 4 Employer Reports, 3 of the matters were addressed through Registrar action in which the Members subject to the reports entered Acknowledgements and Undertakings agreeing to remedial learning and practice reflection. The final Employer Report was concluded after additional follow-up with the relevant parties, as the Registrar did not have reasonable and probable grounds to refer the matter to the ICRC.

Policy Framework:
The ICRC continues to review its public facing documents according to the new policy framework.

Respectfully submitted,
Jeff Earnshaw, RRT
Inquiries, Complaints and Reports Committee Chair

Agenda Item #:	*5.7*
Item:	*Discipline Committee Report*

DISCIPLINE COMMITTEE REPORT – CHAIR'S REPORT TO COUNCIL

May 28, 2021 to September 23, 2021

Since the last Council meeting there have been no Discipline hearings, nor referrals to the Discipline Committee.

Respectfully submitted,
Lindsay Martinek, RRT
Discipline Committee Chair

Agenda Item #:	*5.8*
Item:	*Fitness to Practise Committee Report*

FITNESS TO PRACTISE COMMITTEE REPORT – CHAIR'S REPORT TO COUNCIL

May 28, 2021 to September 23, 2021

Since the last Council meeting there have been no new referrals to the Fitness to Practise Committee and no Fitness to Practise hearings have taken place.

Respectfully submitted,
Lindsay Martinek, RRT
Fitness to Practise Committee Chair

Council Briefing Note

AGENDA ITEM # 7.1 **September 24, 2021**

From:	*Inquiries, Complaints and Reports Committee*
Topic:	*Revised Registrar's Reasonable and Probable Grounds Policy*
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: *Revised policy* Appendix B: *Consultation survey results*

PUBLIC INTEREST RATIONALE:

This policy allows the Registrar to take action to address information received regarding alleged conduct of a member that could pose harm to the public, by establishing the criteria the Registrar will consider in determining an appropriate regulatory response to the alleged conduct. The policy has been reviewed and revised to ensure it is current and continues to serve the public interest.

ISSUE:

The Registrar's Reasonable and Probable Grounds Policy was last reviewed on September 25, 2015. Due to the new policy framework this document was updated to the new template. This document was reviewed by external legal counsel, to ensure that all legislative and regulatory requirements have been met.

BACKGROUND:

This policy sets direction that is not explicitly stated in the *Health Professions Procedural Code* (the "*Code"*) in which the Registrar may exercise their discretion when information comes to the CRTO's attention about a Respiratory Therapists conduct or actions.

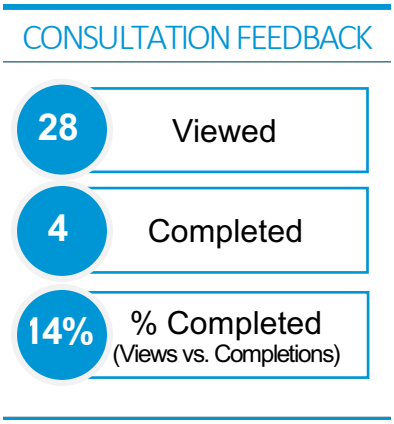
Under the *Regulated Health Professions Act, 1991 (RHPA)* and the *Code*, employers are obligated to submit reports to the CRTO for numerous reasons including professional misconduct, malpractice, negligence, incompetence, incapacity, or sexual abuse.

In addition, members are obligated to report information to the CRTO for numerous reasons including offences, or if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College has sexually abused a patient.

ANALYSIS:

Summary of Changes
Although the format of the policy has been revised, its intent and direction have not changed. The most notable change is in the "Responsibilities" section of the Policy. This section outlines a clearer description of the possible action the Registrar may take when responding to information received about a member, to facilitate a better understanding of the implementation of this 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 and tweeted on the CRTO Twitter account.
In total, 28 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. One comment was received, stating that the policy allows for "great latitude/subjectivity" in considering appropriate action to take. No changes were made to the Policy as a result of this feedback.

For full consultation results see appendix B.

Date consultation opened: July 26, 2021
Length of time consultation was open: 30-days
Date consultation closed: August 26, 2021

RECOMMENDATION:

It is recommended that the CRTO Council approve the Registrar's Reasonable and Probable Grounds 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 bulletin.

Council Motion

AGENDA ITEM # 7.1

Motion Title:	*Revised Registrar's Reasonable and Probable Grounds Policy*
Date of Meeting:	*September 24, 2021*

It is moved by _____ and seconded by _____ that:

The Council approve the revised *Registrar's Reasonable and Probable Grounds Policy*. (A copy is attached as Appendix A to this motion within the materials of this meeting).

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Registrar's Reasonable and Probable Grounds

Type: Policy

Origin Date: September 25, 2015

Section: CD

Approved By Council on: Month Day, Year

Document Number: CD - 150

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 information comes to the attention of the Registrar regarding a member (that is not received by the CRTO through a formal complaint), such as reports by members of the same or a different College, facilities, or employers, the Registrar has a responsibility and obligation to take the steps necessary to address the alleged conduct or actions of a member.

2.0 PURPOSE

The purpose of this policy is to provide clarity that when information about a member's conduct or actions is received by the CRTO, the Registrar considers possible outcomes set out in this policy, in order to address and if required, take further action regarding the member's conduct or actions.

3.0 SCOPE OF POLICY

Members of the CRTO have an obligation to perform their duties under the following:
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*.

It is important to note that the CRTO only has jurisdiction over individuals who were, or are, members of the CRTO at the time of the alleged conduct or actions.

4.0 APPLICABILITY

This policy applies to all individuals who held or hold a certificate of registration with the CRTO at the time of the alleged conduct or actions. Based on the information received, the Registrar considers the following factors:

- Action(s) taken by the employer or facility regarding the matter,
- Prior history of the member,

- Action(s) taken by the member,
- Mitigating or aggravating factors,
- Seriousness of, or risk(s) associated with, the reported conduct or behaviour,
- Outcomes from past matters of a similar nature, and
- Any additional information the Registrar believes to be relevant regarding the matter.

5.0 AUTHORITY

The Registrar receives information pursuant to the *Health Professions Procedural Code*[1] (*the Code*) being Schedule 2 to the *Regulated Health Professions Act, 1991,* (*RHPA*). Sections 85.1 to section 85.6.4 of the *Code* set out the requirements of reporting by members of the same or a different College, facilities, and employers.

6.0 RESPONSIBILITIES

It is the responsibility of the Registrar, upon review of the member's conduct or actions, to:

a. Take no further action and notify the member, should the Registrar determine, based on the above factors, that they do not have reasonable and probable grounds to believe that the member may have committed an act of professional misconduct, is incompetent, or incapacitated.
b. Request and obtain additional information from the parties involved in order to determine if the member may have committed an act of professional misconduct, is incompetent, or incapacitated.
c. Not refer the matter to a Panel of the Inquiries, Complaints and Reports Committee (ICRC) in exchange for the member engaging in remedial practice reflection that is not inconsistent with the *RHPA*, the *Code*, or By-law 25.
d. Refer the matter to a Panel of the Inquiries, Complaints and Reports Committee (ICRC) and request that the ICRC approve an appointment of an investigator to investigate the conduct or actions of the member. This is outlined under S.75.(1)(a) of the *RHPA*.

7.0 MONITORING

It is the responsibility of CRTO staff to carry out and fulfill the directions as given by the Registrar.

8.0 RELATED DOCUMENTS

Regulated Health Professions Act, 1991, being Schedule 2, of the *Health Professions Procedural Code*

Respiratory Therapy Act, 1991, Ontario Regulation 753/93, Professional Misconduct

CRTO By-Law 25

[1] *Regulated Health Professions Act, 1991*, Schedule 2, *Health Professions Procedural Code*

9.0 ABBREVIATIONS

CRTO – College of Respiratory Therapists of Ontario
ICRC – Inquiries, Complaints and Reports Committee
RHPA – Regulated Health Professions Act
The Code – Health Professions Procedural Code

10.0 CONTACT INFORMATION

For further information please contact the CRTO at:

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 E-mail:
questions@crto.on.ca

Answers to Questions

CD-150 Registrar's Reasonable and Probable Grounds Policy Consultations 2021

As of: 8/29/2021 9:22:23 PM

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: Is the purpose of the Registrar's Reasonable and Probable Grounds Policy clear?

Number Who Answered: 4

Yes	No
4	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Do you agree that the Registrar's Reasonable and Probable Grounds Policy is clear and understandable?

Number Who Answered: 4

Yes	No
4	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Is the Registrar's Reasonable and Probable Grounds 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: Does this Registrar's Reasonable and Probable Grounds Policy provide you with sufficient understanding of the expectations?

Number Who Answered: 4

Yes	No
4	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: 1

1. not sure of errors and omissions, seem like great latitude/subjectivity in considerations whether to take action against member or not.

Council Briefing Note

AGENDA ITEM # 7.2 **September 24, 2021**

From:	*Inquiries, Complaints and Reports Committee*
Topic:	*Revised Reporting to Police Policy*
Purpose:	*For Decision*
Strategic Focus:	*That the CRTO meets and fulfills its mandate of public protection*
Attachment(s):	Appendix A*: Revised policy* Appendix B: *Consultation survey results*

PUBLIC INTEREST RATIONALE:

This policy provides the CRTO with the authority to respond to information from stakeholders and the public regarding alleged conduct or actions of Respiratory Therapists. It establishes the authority upon which the Registrar can rely to report information about a member to the police in situations where the Registrar is of the opinion that the conduct or actions of a member may be criminal in nature.

ISSUE:

The Reporting to Police Policy was last reviewed on September 25, 2015. Due to the new policy framework, this policy was updated in the new 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 staff that is not explicitly stated in the *Regulated Health Professions Act, 1991* (RHPA), and the *Health Professions Procedural Code* (the *"Code"*), being Schedule 2 of the *RHPA*.

There may be instances when information comes to the attention of the CRTO which provides the Registrar with reasonable and probable grounds that a member may be incompetent, incapacitated or has committed act(s) of professional misconduct. In cases where the Registrar is also of the opinion that the conduct of the member may be criminal in nature, this policy helps to guide the process for disclosing information to the police.

ANALYSIS:

Summary of Changes

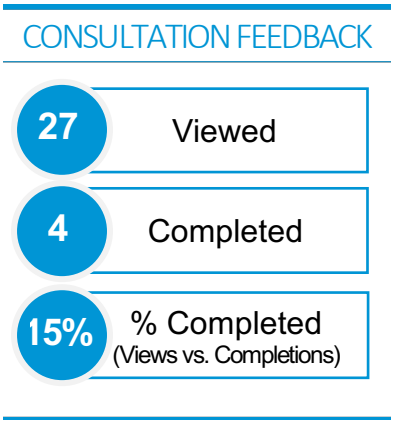
Based on legal advice, the existing Reporting to Police Policy did not meet the CRTO's obligation of a member's right to confidentiality. The revised version of this policy sets out that the CRTO will not inform third parties that the matter has been reported to the police by the CRTO, therefore adhering to the member's right to confidentiality.

In addition, the existing Reporting to Police Policy directed parties involved in the matter to contact police. The revised version of this policy allows the CRTO to directly report to the police instead of encouraging the parties. This allows the CRTO to meet its mandate of public protection by ensuring police are notified of possible criminal conduct when warranted, instead of relying on third parties.

The changes made to this policy are consistent with current policies and positions of the CRTO as this policy strengthens the CRTOs commitment to transparency by stating the possible actions the CRTO may take to all stakeholders 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, 27 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. Two comments were received, one identifying three process questions and a request to define terminology. The other comment noted that they were unable to confirm whether the policy had errors or omissions (see Appendix B). No changes were made to the Policy as a result of this feedback.

For full consultation results see appendix B.

Date consultation opened: July 26, 2021
Length of time consultation was open: 30-days
Date consultation closed: August 26, 2021

RECOMMENDATION:

It is recommended that the CRTO Council approve the Reporting to Police 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 bulletin.

Council Motion

AGENDA ITEM # 7.2

Motion Title:	*Revised Reporting to Police Policy*
Date of Meeting:	*September 24, 2021*

It is moved by _____and seconded by _____ that:

The Council approve the revised *Reporting to Police Policy*. (A copy is attached as Appendix A to this motion within the materials of this meeting).

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Reporting to Police

Type: Policy

Origin Date: September 25, 2015

Section: CD

Approved By Council on: Month Day, Year

Document Number: CD-140

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 information comes to the attention of the Registrar and the Registrar is of the opinion that the conduct or actions of a member may be criminal in nature, the Registrar may disclose any relevant information to the police regarding the member.

2.0 PURPOSE

The purpose of this policy is to carry out CRTO's mandate of acting in the interest of the public.

3.0 APPLICABILTY

There may be instances when information comes to the attention of the CRTO which provides the Registrar with reasonable and probable grounds that a member may be incompetent, incapacitated or has committed act(s) of professional misconduct. In cases where the Registrar is also of the opinion that the conduct of the member may be criminal in nature, this policy will help to guide the process for disclosing information to the police.

4.0 RESPONSIBILITIES

If the CRTO initiates reporting a matter to the police, the CRTO will provide notice to the member that the information is being shared with police, only if this notice would not interfere, jeopardize, or otherwise cause significant harm.

If the CRTO reports a matter to the police, due to strict confidentiality provisions within the RHPA, it is unable to notify third parties that the matter has been reported.

The CRTO utilizes the *Disclosure of Personal Information to Law Enforcement* Fact Sheet published by the Information and Privacy Commissioner of Ontario when disclosing information about a member.

5.0 AUTHORITY & MONITORING

The Registrar shall disclose information to the police, as permitted by section 36(1) of the *Regulated Health Professions Act, 1991 (RHPA)*.

6.0 CONSIDERATIONS

If the source of the information has indicated that they will not or have not reported the conduct or actions of the member to the police, the Registrar may report the member's conduct and actions to the police if the Registrar is of the opinion that:

a. The alleged conduct and actions appear to be criminal in nature,
b. There may be a significant risk to public safety by not reporting, and
c. The CRTO is in possession of additional information (such as the member's prior history with the CRTO), that reasonably suggests that the alleged conduct may be indicative of a pattern of behaviour that is escalating in severity.

7.0 RELATED DOCUMENTS

Section 36(1) of the *Regulated Health Professions Act, 1991 (RHPA)*

Registrar's Reasonable and Probable Grounds Policy

Disclosure of Personal Information to Law Enforcement, Information and Privacy Commissioner of Ontario

8.0 ABBREVIATIONS

CRTO – College of Respiratory Therapists of Ontario
RHPA – Regulated Health Professions Act

9.0 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

Answers to Questions
CD-140 Reporting to Police Policy Consultations 2021
As of: 8/30/2021 12:04:30 AM

Page: About You

Question: Are you a...

Number Who Answered: 4

Respiratory Therapist (including retired)	4	100%

Question: I live in...

Number Who Answered: 4

Ontario	4	100%

Page: Questions

Question: Is the purpose of the Reporting to Police Policy clear?

Number Who Answered: 4

Yes	No
4	0
100%	0%

Question: If no, please provide further details:

Number Who Answered: 0

Question: Do you agree that the Reporting to Police Policy is clear and understandable?

Number Who Answered: 4

Yes	No
4	0
100%	0%

Question: If no, please provide further details:

Number Who Answered: 0

Question: Is the Reporting to Police 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: Does this Reporting to Police Policy provide you with sufficient understanding of the expectations?

Number Who Answered: 4

Yes	No
4	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: 2
1. *What constitutes "reasonable and probable grounds"? Is the process initiated based upon hearsay or reported by a third-party? What steps would the CRTO take to ensure that the allegations are substantiated before reporting to the police? Is it an individual or a committee that decides if the matter is to be reported to the police? There have been incidences reported in the news whereby allegations are laid against the accused only to be discovered that they were baseless and unfounded. Hence, there are two unfortunate consequences as a result, if the allegations eventually were deemed to be false: (1) Would the CRTO make a formal apology to the accused? (2) If the police investigate and nothing further comes of it, there is still a record. Any time anyone is involved in what is suspected to be a criminal act and are not convicted of a criminal charge, the record of the charge is documented. This may affect the accused's right to livelihood or travel.* ***2.*** *not sure if there are omissions or errors*

AGENDA ITEM # 7.3 **September 24, 2021**

From:	*Registration Committee*
Topic:	*Revised Entry-to-Practice Exam Policy*
Purpose:	*For Decision*
Strategic Focus:	*That the CRTO meets and fulfills its Mission Statement and remains current with legislation, Member's obligations, and the public's expectations.*
Attachment(s):	Appendix A - *Revised policy* Appendix B **-** *Consultation survey results*

PUBLIC INTEREST RATIONALE:

This policy provides applicants with the entry-to-practice requirements in an accountable, transparent and equitable process. The policy has been reviewed and revised to make sure it is current and continues to serve the public interest.

ISSUE:

The Entry-to-Practice Exam Policy was last approved by Council on December 3, 2010. Due to the new policy framework this document was updated the the new template. There were no significant changes to the policy.

BACKGROUND:

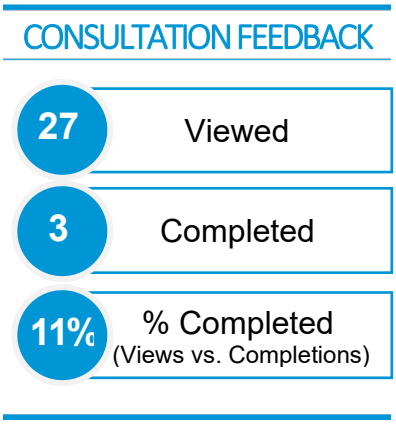
This policy sets the direction for the Entry-to-Practice Exam requirements authorized by the CRTO that are not explicitly stated in the *Registration Regulation (O. Reg 596/94)*. This policy applies to CRTO applicants for registration.

The policy is consistent with current practices in how applicants are considered for a general certificate of registration and does not change existing practice.

ANALYSIS:

Summary of Changes
Although the format of the policy has been revised, its intent and direction has not changed. 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 and shred in the July eBulletin to Members. In total, 27 people viewed the consultation survey, and 3 responses were received.



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 for feedback: July 26, 2021
Length of time posted for consultation: 30-days
Date consultation closed: August 26, 2021

RECOMMENDATION:
It is recommended that the CRTO Council approve the revised Entry-to-Practice Exam Policy as per the attached Motion.

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

AGENDA ITEM # 7.3

Motion Title:	*Revised Entry-to-Practice Exam Policy*
Date of Meeting:	*September 24, 2021*

It is moved by _____ and seconded by _____ that:

The Council approve the revised *Entry-to-Practice Exam Policy*. (A copy is attached as Appendix A to this motion within the materials of this meeting).

Entry-to-Practice Exam Policy

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Entry-to-Practice Exam Policy

Type: Registration

Origin Date: June 10, 2005

Section: RG

Approved By Council on: December 3, 2010

Document Number: RG-406

Next Revision Date:

1.0 POLICY STATEMENT

The Council of the College of Respiratory Therapists of Ontario ("CRTO") accepts the Canadian Board for Respiratory Care ("CBRC") examination as the national certification exam for entry-to-practice requirements.

2.0 PURPOSE

This policy provides direction governing the entry-to-practice examination requirements authorized by the CRTO.

3.0 APPLICABILITY & SCOPE OF POLICY

Prior to 2003, the CRTO also accepted the CRTO's Core Competencies Evaluation as the national certification exam for entry-to-practice. As of December 2003, the CRTO no longer offers the Core Competencies Evaluation.

- Applicants
  - Applicants for registration will initially be allowed up to three attempts to write the CBRC examination.
  - For each subsequent attempt, the applicant must submit to the CRTO an upgrading study plan for review and approval. The purpose of the review is to verify that the applicant has undertaken a systematic approach in preparing to re-write the exam and to provide the applicant with feedback concerning the content of their study plan which may assist them in successfully completing the examination.

4.0 RELATED DOCUMENTS

- O. Reg. 596/94: GENERAL (ontario.ca)
- The Canadian Board for Respiratory Care Inc.
- Registration Exam Procedure
- Examination Fact Sheet
- Study Plan Guide

5.0 CONTACT INFORMATION

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Suite 2103
Toronto, ON M5G 1Z8
Canada

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416-591-7800

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General Email:
questions@crto.on.ca

Answers to Questions

RG-406 Reg Exam Policy Consultations 2021

As of: 8/29/2021 9:55:24 PM

Page: About You

Question: Are you a...

Number Who Answered: 4

Respiratory Therapist (including retired)	3	75%
Member of the Public	1	25%

Question: I live in...

Number Who Answered: 4

Ontario	4	100%

Page: Questions

Question: Is the purpose of the Entry-to-Practice Exam Policy clear?

Number Who Answered: 3

Yes	No
3	0
100 %	0 %

Question: If no, please provide further details:

Number Who Answered: 0

Question: Do you agree that the Entry-to-Practice Exam 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: Is the Entry-to-Practice Exam 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: Does this Entry-to-Practice Exam 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

AGENDA ITEM # 7.4 **September 24, 2021**

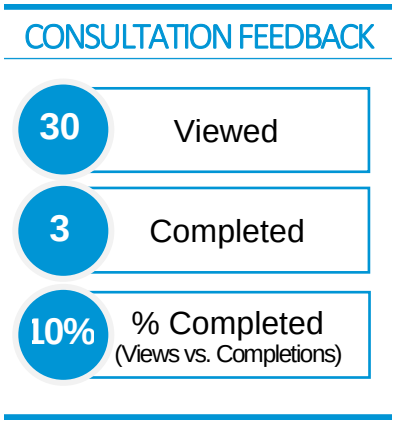
From:	*Kelly Arndt, RRT Quality Practice Coordinator*
Topic:	***Draft** Handling, Administration and Dispensing of Controlled Substances Practice Policy*
Purpose:	*For Decision*
Strategic Focus:	*Protecting patient safety by ensuring that Respiratory Therapists understand their professional responsibilities and obligations in the handling of Controlled Substances*
Attachment(s):	Appendix A – *New Handling, Administration and Dispensing of Controlled Substances Practice Policy* Appendix B – *Consultation Survey Results*

PUBLIC INTEREST RATIONALE:
Ensuring that Respiratory Therapists understand the expectations and professional responsibilities in the Handling, Administration and Dispensing of Controlled Substances will protect patient safety and prevent public harm. A controlled substance is one that Health Canada has determined to have significant potential for addiction and abuse, including prescription medications and illegal street drugs.

ISSUE:
This information previously existed as a Position Statement, created July 2014. This document has been converted into a new Professional Practice Policy. Professional Practice Policies set out expectations and responsibilities for Members beyond what is outlined in the Standards of Practice.

BACKGROUND:
This policy has been revised and updated into a new Professional Practice Policy to align with the CRTO's Policy Framework. This new category of policies will help provide a strong framework to enhance the understanding of the role that Respiratory Therapists (RTs) hold to ensure public/patient safety in the use of narcotics in the healthcare environment.

ANALYSIS:
The document was posted for public consultation on the CRTO website along with a consultation survey for participants to provide feedback. The survey was also tweeted on the CRTO Twitter account.



There were **two** comments received in the survey:

1. The examples of when it would be administering vs dispensing (procedural sedation vs taking out fentanyl for later use) are good and easy to understand (as in current policy) Any examples applied to workplace are helpful Thanks.
2. It is not clear why a medical for the administration of a narcotic.

One Member disagreed with the statement that the purpose of the policy was clear, that the policy itself was clear and free from errors.

For full consultation results see appendix B.

Date consultation opened: July 26, 2021
Length of time consultation was open: 30-days
Date consultation closed: August 26, 2021

While the CRTO's Administration and Dispensing of Medications Professional Practice Guideline does touch on Narcotics, this Professional Practice Policy outlines the specific responsibilities for the handling of all controlled substances.

The anticipated ongoing climate of narcotic misuse is a reality. The CRTO will continue to provide its Members with the most up to date Practice Policy surrounding this topic.

RECOMMENDATION:
It is recommended that Council review and approve the policy.

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

AGENDA ITEM # 7.4

Motion Title:	*Final Draft Handling, Administration and Dispensing of Controlled Substance Practice Policy*
Date of Meeting:	*September 24, 2021*

It is moved by _____ and seconded by _____ that:

Council approves the *Final Draft Handling, Administration and Dispensing of Controlled Substance Practice Policy* for publication. (A copy is attached as Appendix A to this motion within the materials of this meeting.)

New Handling, Administration and Dispensing of Controlled Substances Practice Policy to replace the Handling, Administration and Dispensing of Controlled Substances Position Statement.

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Handling, Administration and Dispensing of Controlled Substances

Type: Professional Practice Policy	**Origin Date:** Council Approval Date (September 24, 2021)
Section: PP	**Approved By Council on:** Month Day, Year
Document Number: PP-105	**Next Revision Date:** 5 Years After Approval September 2026

1.0 PRACTICE POLICY STATEMENT

The CRTO considers it acceptable for a Respiratory Therapist (RT) to handle, administer and accept delegation to dispense controlled substances, provided that appropriate authorizing mechanisms are in place.

2.0 PURPOSE

The CRTO is committed to providing guidance surrounding the handling, administration and dispensing of controlled substance to its Members. The purpose of this policy is to provide a strong framework to enhance the understanding of the role that RT's hold to ensure public and patient safety in the use of narcotics in the healthcare environment.

3.0 APPLICABILTY & SCOPE OF POLICY

- RT's who hold an Active General or Graduate Certificate of Registration with the CRTO with no terms, conditions or limitations preventing them from performing any authorized acts, may handle, administer, and dispense controlled substances, provided they have a valid order. While the list is not specific, the CRTO's ***Interpretation of Authorized Acts*** Professional Practice Guideline (PPG) provides examples of medications that RT's may administer.

4.0 RESPONSIBILITIES

- **Scope of Practice and Competencies:** It is an expectation that any activity or procedure performed by an RT, including the administration of a controlled substance, falls within the RT's professional and personal scope of practice. As with any task undertaken as part of their clinical practice, an RT must also have the requisite knowledge, skills, and judgment (competencies).

- **Delegation to Dispense:** One of the 13 controlled acts in the *Regulated Health Professions Act (RHPA)* is "*prescribing, dispensing, selling or compounding a drug*…". Since the *Respiratory Therapy Act (RTA)* does not authorize RTs to perform this controlled act, the authority to dispense medications must be delegated to an RT from another regulated health care professional that is authorized to dispense and to delegate dispensing. Dispensing occurs when an RT is required to select, prepare, package, and transfer stock medication for one or more prescribed medication doses to a patient for administration at a later time.
- The rules surrounding dispensing are the same regardless of the substance and the CRTO is of the position that there is nothing in current provincial or federal legislation to prevent an RT from receiving delegation to dispense a controlled substance. **Note:** RTs can accept delegation to dispense, but cannot receive delegation to prescribe, sell or compound a drug.

- **Authorization to Possess and Administer a Controlled Substance:** RTs can only obtain possession of a controlled substance through a prescription issued by an authorized practitioner; usually a physician (please note NP-ECs cannot currently prescribe a controlled substance). The *Controlled Drugs and Substances Act (CDSA)* states that physicians must name the individual patient in the prescription. Because of this restriction, medical directives for a broad range of patients cannot be used to gain possession of a controlled substance. Once the RT is in legal possession of the controlled substance, they may administer the medication via a direct order for a specific patient. **Note:** medical directives cannot be used to authorize the handling, administration or dispensing of a controlled substance.

- **Handling and Storage of Controlled Substances:** The *Narcotics Control Regulation (NCR)* [s.3 (1)] defines "a hospital employee" as someone who is authorized to handle a controlled substance (e.g., picking up narcotics from a pharmacy and transporting them to where they will be administered to the patient). Therefore, the CRTO interprets this to authorize RTs employed at a hospital to handle and transport controlled substances. It is important that RT's, along with all practitioners and staff, play a role in the safety, security, and disposal of controlled substances to avoid narcotic diversion.

5.0 AUTHORITY & MONITORING

- A controlled substance is one that Health Canada has determined to have significant potential for addiction and abuse, including prescription medications and illegal street drugs.
- The possession, handling, dispensing and administration of controlled substances are governed primarily by federal legislation; the *Controlled Drug and Substances Act (CDSA)* and the *Narcotics Control Regulations (NCR).*
- The *CDSA* lists all controlled substances, which includes narcotic analgesics (e.g. Fentanyl), non-narcotic controlled drugs such as benzodiazepines (e.g. Midazolam) and barbiturates (e.g. Phenobarbital).
- The *NCR* deals specifically with how hospitals and pharmacies are licensed to handle controlled substances.

6.0 RELATED DOCUMENTS

- ***CRTO's Standards of Practice;***
- ***CRTO's Administering and Dispensing PPG;***
- ***CRTO's Orders for Medical Care PPG;***
- ***Regulated Health Professions Act (RHPA);***
- ***Respiratory Therapy Act (RTA);***
- ***Drug and Pharmacies Regulation Act;***
- ***Narcotics Safety and Awareness Act; and***
- ***Controlled Drugs and Substance Act and Regulation (Health Canada)***

7.0 APPENDICES

Authorizing Mechanisms for Controlled Substances

	Medical Directive allowed?	Direct Order required? (i.e., patient specific)	Delegation required?
Handling (e.g., transporting)	No	Yes	No
Administration	No	Yes	No
Dispensing	No	Yes	Yes

8.0 CONTACT INFORMATION

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

Telephone: 416-591-7800
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Answers to Questions

PP-105 Narcotics Professional Practice Policy Consultation 2021

As of: 8/30/2021 12:04:30 AM

Page: About You

Question: Are you a...

Number Who Answered: 4

Respiratory Therapist (including retired)	4	100%

Question: I live in...

Number Who Answered: 4

Ontario	4	100%

Page: Questions

Question: Is the purpose of the Handling, Administration and Dispensing of Controlled Substances professional practice policy clear?

Number Who Answered: 4

Yes	No
3	1
75%	25%

Question: If no, please provide further details:

Number Who Answered: 1

1. It is not clear why a medical for the administration of a narcotic

Question: Do you agree that the Handling, Administration and Dispensing of Controlled Substances professional practice policy is clear and understandable?

Number Who Answered: 4

Yes	No
3	1
75%	25%

Question: If no, please provide further details:

Number Who Answered: 0

Question: Is the Handling, Administration and Dispensing of Controlled Substances professional practice policy 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: 4. Does this Handling, Administration and Dispensing of Controlled Substances professional practice policy provide you with sufficient understanding of the expectations?

Number Who Answered: 3

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: 1

1. The examples of when it's would be administering vs dispensing (procedural sedation vs taking out fentanyl for later use) are good and easy to understand (as in current policy) Any examples applied to workplace are helpful Thanks

AGENDA ITEM # 7.5 **September 24, 2021**

From:	*Carole Hamp, RRT, Acting Registrar*
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 Committee Members Policy* *Appendix B: Former Member Information on the Public Register Policy* *Appendix C: Public Register Fact Sheet* *Appendix D: Obtaining Court Transcripts Policy* *Appendix E: Mandatory Reporting for Members Fact Sheet* *Appendix F: Assessing Suitability to Practise Policy* *Appendix G: Determining Applicants' Suitability to Practise Policy* *Appendix H: Determining Applicants' Suitability to Practise Fact Sheet* *Appendix I: Terms, Conditions and Limitations Policy* *Appendix J: Terms, Conditions and Limitations Fact Sheet*

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, it has been determined that several policies are repetitive, or reference 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, D, F, G and I) be rescinded and archived to increase clarity and avoid potential discrepancies between various guiding documents.

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

- **Appointment of Council and Committee Members Policy (Appendix A)**
  This policy references the CRTO By-Law, therefore the information contained regarding Committee Appointments is redundant. The policy does not provide new direction to the CRTO beyond what is outlined in the By-law. The Checklist for appointments within the policy will be used as part of the By-law procedures.

- **Former Member Information on the Public Register Policy (Appendix B)**
  This policy references a specific section of the CRTO By-Law that has changed from 31.06 to 34.11. The *Code* and CRTO By-Law 25-2019 state the required information that must be included on the public register and must be complied with, therefore a policy is not needed. A fact sheet has been created to specify the necessary contents of the public register (see *Appendix C* for reference).

- **Obtaining Court Transcripts Policy (Appendix D)**
  The information contained within this policy is stated in the *Code*. As the information is in legislation it is better suited to have this information within a fact sheet on the website. This information is being included in the existing, Mandatory Reporting by Members fact sheet (see *Appendix E* for reference). Some of the contents of this policy have been transferred to the Registrar's Reasonable and Probable Grounds Procedure.

- **Assessing Suitability to Practise Policy (Appendix F)**
  The Assessing Suitability to Practise policy (formerly Reinstatement of Former Members Found Guilty of Sexual Abuse) is explicitly stated in the *Code*. The policy does not provide new direction to the CRTO, therefore is not needed. However, this information will remain available on the website by information being included in the existing Mandatory Reporting by Members fact sheet (see *Appendix E* for reference).

- **Determining Applicants' Suitability to Practise Policy (Appendix G)**
  This policy describes section 53 of the *Respiratory Therapy Act* and its applicability when considering registering applicants with conduct-related concerns. The policy does not provide new direction to the CRTO, therefore is not needed. This policy has been redeveloped as a fact sheet (see *Appendix H* for reference) to guide the applicants and the Registration Committee when considering an applicants' suitability to practice.

- **Terms, Conditions and Limitations Policy (Appendix I)**
  The contents of this policy are currently covered in the Currency Policy, and various legislation (e.g., *Health Professions Procedural Code*, and the *Respiratory Therapy Act*). As this policy does not provide new direction to the CRTO, it is not needed. Terms, Conditions and Limitations imposed by specific regulations cannot be varied (e.g., the *Controlled Acts Regulation*, *Prescribed Procedures Regulation*, the *Respiratory Therapy Act*). This policy has been redeveloped as a fact sheet (see *Appendix J* for reference) providing resources for members who are seeking to vary/lift the TCLs imposed on their certificate of registration by the Registration Committee.

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. In addition, the fact sheets will be posted on the website and communicated to the members in the next bulletin.

AGENDA ITEM # 7.5

Motion Title:	*Consent Agenda Items For Policies Being Rescinded & Archived*
Date of Meeting:	*September 24, 2021*

It is moved by _____ and seconded by _____ that:

The CRTO Council approves the items outlined in the policies being rescinded & archived consent agenda (item 7.5), which include in their entirety:

- Appointment of Council and Committee Members Policy (Appendix A)
- Former Member Information on the Public Register Policy (Appendix B)
- Obtaining Court Transcripts Policy (Appendix D)
- Assessing Suitability to Practise Policy (Appendix F)
- Determining Applicants' Suitability to Practise Policy (Appendix G)
- Terms, Conditions and Limitations Policy (Appendix I)

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO		
	Title: **Appointment of Committee Members**	Number: **CP-Appt.Ctte.Memebers-210**
	Date originally approved: **June 1, 2018**	Date(s) revision approved: **N/A**

POLICY

Effective functioning of the College's Committees is dependent on the ongoing process of appointing Council and Non-Council members on an annual basis.

Executive Committee

- In accordance with the By-Laws the Executive Committee shall be elected from Council members.

All other Committees

- In accordance with the By-Laws (articles 23 – 29) the Executive Committee shall appoint Council and Non-Council members to each Committee. In addition to the By-Laws the Executive Committee will also utilize The Committee Appointment Guidelines (Appendix A)

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: Former Member Information on the Public Register

Number: **RG–Former Member Info on Public Register-417**

Date originally approved:
September 24, 2010

Date(s) revision approved:
May 25, 2012

POLICY

With respect to former members (individuals who ceased to be members as of June 4, 2009) and in accordance with Article 31.06 of the CRTO By-law, the register shall contain a notation specifying the reason for the termination of membership and the date upon which the member ceased to be a member for a period of ten years after the termination of membership, except for any information related to discipline proceedings in Ontario, in which case it shall be entered on the register for a period of fifty years after the termination of membership.

Attached is the new Public Register fact sheet for reference, this fact sheet has been created to specify the necessary contents of the public register for replacing the policy noted in Appendix B.

Overview

The CRTO must provide certain information about Respiratory Therapists on the public register.

In order to fulfill its mandate of public protection, transparency, and accountability, the CRTO must ensure that the public register contains information about its membership as set out in legislation and the CRTO By Laws.

The purpose of this Fact Sheet is to specify information that must be on the public register. The listed requirements of the public register are categorized in relation to registration, professional conduct, and miscellaneous items.

For a complete list of information required of the public register, please refer to the *Regulated Health Professions Act, 1991* (*RHPA*) being Schedule 2 of the *Health Professions Procedural Code* (the *Code*) and CRTO By-Law-25 2019. Additional information can be obtained by speaking directly with a CRTO staff member.

Contents of the Register under the *Health Professions Procedural Code* (the *Code*) and the CRTO By-Law 25-2019

Registration

The public register of an individual registered with the CRTO must contain the following information:

- The Member's name and if there have been any changes to the Member's name since the date of the Member's initial application for registration, the former name(s) of the Member.
- The name, address, and telephone number of every employer that the member is employed as a respiratory therapist.

  If the member is self-employed as a respiratory therapist, the address and telephone number of every location where the member practices other than addresses of individual clients.
- For each practice location the area of practice identified by the Member as their "main area of practice".
- The name, business address and business telephone number of every health profession corporation, the name of every health profession corporation of which the member is a shareholder.
- Each Member's class of registration, specialist status, and the date on which the Member's current certificate was issued and cessation or expiration date.

- The Member's registration number and current registration status.
- The language(s) in which the Member is able to provide respiratory therapy services.
- The terms, conditions and limitations that are in effect on each certificate of registration.
- Where the Member's certificate of registration is subject to a suspension for failure to pay a fee or failure to complete his or her registration renewal, the reason for the suspension and the date of the suspension in addition to the fact of the suspension.

Professional Conduct

Certain information regarding the conduct or actions of a Member must be included on the CRTO's public register as outlined in the *Health Professions Procedural Code* and *CRTO By-Laws*. This includes:

- Where the Member's certificate of registration is subject to an interim order (e.g., terms, conditions, limitations, or suspension), a notation of that fact, the nature of the order and the date that the order took effect.
- Information regarding registration with any other body that governs a profession, including disciplinary findings, whether inside or outside of Ontario made after January 1, 2016.
- A notation of every caution that a member has received from a panel of the Inquiries, Complaints and Reports Committee and any specified continuing education or remedial programs required by a panel of the Inquiries, Complaints and Reports Committee.
- A notation of every matter that has been referred by the Inquiries, Complaints and Reports Committee to the Discipline Committee and that has not been finally resolved, including the date of the referral and the status of the hearing before a panel of the Discipline Committee, until the matter has been resolved.
- A copy of the specified allegations against a member for every matter that has been referred by the Inquiries, Complaints and Reports Committee to the Discipline Committee that has not been finally resolved.
- Every result of a disciplinary or incapacity proceeding.
- Where findings of the Discipline Committee are appealed, a notation that they are under appeal, until the appeal is finally disposed of.
- A notation and synopsis of any acknowledgements and undertakings in relation to matters involving allegations of professional misconduct or incompetence before the Inquiries,

Complaints and Reports Committee or the Discipline Committee that a member has entered into with the CRTO and that are in effect.

- A notation of every finding of professional negligence or malpractice, which may or may not relate to the member's suitability to practise, made against the member, unless the finding is reversed on appeal.
- A notation of every revocation or suspension of a certificate of registration or authorization.
- Information that a panel of the Registration Committee, Discipline Committee or Fitness to Practise Committee specifies will be included.
- Where, during or as a result of a proceeding, a member has resigned and agreed never to practise again in Ontario, a notation of the resignation and agreement.

A Member of the CRTO is obligated to report offences, charges, and findings under numerous legislations in Ontario. The following must be included on a member's public register:

- Where a Member has been charged with an offence on or after January 1, 2016 under the *Criminal Code of Canada,* or under the *Health Insurance Act*, or under the *Controlled Drugs and Substances Act (Canada),* or any other offence that relates to the Member's suitability to practice, the fact and content of the charge and, where applicable bail conditions and, where known the date and outcome of the charge(s).
- Information about a finding by a court made after January 1, 2016 that the Member has been found guilty of an offence under the *Criminal Code of Canada*, or under the *Health Insurance Act*, or under the *Controlled Drugs and Substances Act (Canada)*, or any other offence that relates to the Member's suitability to practise, including:
    i. the date and a summary of the finding,
    ii. the date and the sentence imposed, if any, and
    iii. where the finding is under appeal, a notation to that effect;

Miscellaneous

- Any information jointly agreed to be placed on the register by the CRTO and the Member.

- The name and location of practice**,** if known, of individuals reported to the CRTO for holding themselves out as respiratory therapists or as qualified to practise as a respiratory therapist or in a specialty of respiratory therapy, in accordance with S.9 of the *Respiratory Therapy Act, 1991*.

- Where a member is deceased, the name of the deceased member and the date upon which the member died, if known to the Registrar.

Resources

- Section 23(2) of the *Regulated Health Professions Act, 1991* (*RHPA*) being Schedule 2 of the *Health Professions Procedural Code* (the *Code)*
- CRTO By-Law 25-2019

Contact Information

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COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Obtaining Court Transcripts**

Number: **CD–170-Court Transcripts**

Date originally approved:
June 1, 2018

Date(s) revision approved:
N/A

POLICY

In accordance with Article 35 of the By-Laws (Duty to Report), and the Registration Committee's Policy REG-413-Members'-Duty-to-Self-Report, Respiratory Therapists are required to inform the CRTO when they have been charged with an offence under the *Criminal Code of Canada*, or under the *Health Insurance Act*, or under the *Controlled Drugs and Substances Act (Canada)*, or any other offence that related to Members' suitability to practice (e.g., breaching the *Personal Health Information Protection Act, 2004*). This information should be reported as soon as possible after the date of the charge.

In addition to the fact of the charge, Members also must report to the CRTO:

- the content of the charge,
- bail conditions (if applicable),
- the date of the charge,
- date and location of any/all court appearances related to the charge, and
- outcome of the charge (where known).

When information related to a Member's charges are received by the CRTO, an inquiry is initiated in order to assist the Registrar in determining whether there are reasonable and probably grounds to believe that the Member appears to have committed an act of professional misconduct or is incompetent or incapacitated; see CRTO Policy CD-150-Registrar's Reasonable and Probable Grounds for additional information. As a matter of course, the CRTO will request a copy of official court transcripts related to the charges to help inform this process. Court transcripts often provide additional details regarding the circumstances surrounding the charges that may not be disclosed by the Member but are central to the Registrar's evaluation.

Attached is the revised Mandatory Reporting by Members fact sheet for reference, this fact sheet has been revised to include information regarding Obtaining Court Documents for replacing the policy noted in Appendix D.

Overview

As a regulated healthcare professional you are required to report a number of things to the College of Respiratory Therapists of Ontario (CRTO) or other legislated bodies in the interest of public safety and transparency. The purpose of this Fact Sheet is to clarify what needs to be reported, to whom, and under which jurisdiction these reports are required. Additional information can be obtained by speaking directly with a CRTO staff member.

Under what authority am I required to make a report?

Your reporting obligations come from a number of different legal sources including the *Regulated Health Professions Act, 1991,* the *Child and Family Services Act, 1990,* the *Retirement Homes Act, 2010,* and the *CRTO's Regulations*, *Standards of Practice*, *By-Laws* and *Commitment to Ethical Practice*.

What am I required to report to the CRTO?

Mandatory Self-Reporting Obligations

Your reporting obligations fall into three categories:

1. Offences
2. Findings/proceedings of professional negligence or malpractice; or
3. Information regarding professional registration and conduct

1. Offences

You are required to report **any** offence for which you have been charged (including bail conditions, restrictions imposed, or restrictions agreed upon) and/or any findings of guilt, including those:

i) under the *Criminal Code of Canada, 1985;*
ii) under the *Health Insurance Act, 1990;*
iii) related to prescribing, compounding, dispensing, selling or administering drugs;
iv) that occurred while you were practicing, or that was related to your practice;
v) in which you were impaired or intoxicated; or,
vi) not listed but relevant to your suitability to practice the profession.

An example of an offence that might occur while you are practising would be a breach of the *Personal Health Information Protection Act, 2004.*

You are not required to report municipal by-law infractions such as parking and zoning violations, or offences under the *Highway Traffic Act, 1990* such as speeding or rule of the road violations.

However, **all** offences involving the consumption of alcohol or drugs must be reported.

Any offence that involves dishonesty, breach of trust or disregard for the welfare of individuals are examples of offences relevant to your suitability to practice and must be reported (e.g., a failure to report a child in need of protection under the *Child and Family Services Act, 1990).*

When in doubt, you should err on the side of caution and report an offence to the CRTO. The CRTO staff and the relevant committee will review the report to determine if the offence is "relevant to a member's suitability to practice".

2. Findings/Proceedings of Professional Negligence or Malpractice

Professional negligence generally involves making a mistake that harms a patient. These findings occur in civil court proceedings or lawsuits. The CRTO must post court findings of professional negligence or malpractice on the public register.

3. Information regarding Professional Registration and Conduct

You must also notify the CRTO if:

a) you are a member of another body that governs a profession inside or outside of Ontario; and/or
b) you have a finding of professional misconduct, incompetence, incapacity, or similar proceedings made against you by another body that governs a profession inside or outside of Ontario; and/or
c) you have been disciplined, suspended, required to resign, terminated or subjected to similar action at our place of employment or in a relation to a contract of service; and/or
d) you have been the subject of any professional misconduct in relation to a contract of service.

4. Mandatory Reporting Obligations of other Health Care Professionals

Reporting Sexual Abuse of a Patient

Under section 85.1 you must file a report if you have reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College has sexually abused a patient. You must make the report within **30 days**, unless you have reasonable grounds to believe the member will continue to sexually abuse patients, in which case, you must report the information immediately.

Notes:

1. The name of a patient who may have been sexually abused must not be included in a report unless the patient, or if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patient's name.
2. You are not required to file a report if you don't know the name of the member who would be the subject of the report.
3. If a member is required to file a report because of reasonable grounds obtained from one of the member's patients, the member shall use his or her best efforts to advise the patient of the requirement to file the report before doing so.

Timing of Report

The report must be filed as soon as reasonably practicable after the member receives notice of the finding of guilt, charge, bail condition or restriction.

NOTE: for reporting of sexual abuse of a patient, you must make the report within **30 days**, unless you have reasonable grounds to believe the member will continue to sexually abuse patients, in which case, you must report the information immediately.

Contents of Report

The contents of the report must contain:

a. the name of the member filing the report;
b. the nature of, and a description of the finding/charge;
c. the date that the finding/charge was made/laid against the member;
d. the name and location of the court/body that made the finding against the member/the name and location of the court in which the charge was laid or in which the bail condition or restriction was imposed on or agreed to by the member;
e. every bail condition imposed on the member as a result of the charge;
f. any other restriction imposed on or agreed to by the member relating to the charge;
g. the status of any appeal initiated respecting the finding made against the member; and
h. the status of any proceedings with respect to the charge.

What happens after I report an offence or other finding?

The CRTO will review the report and determine if any further investigation is required. You may be asked to provide additional information (e.g., the contact information of the police officer or Crown attorney who knows most about the matter).

In general the CRTO will only take action, if, after inquiring into the matter, it appears that the conduct impacts your ability to practice respiratory therapy ethically, safely or competently.

If I work in a long-term care facility, what do I have to report?

If you have reasonable grounds to suspect that a child may have been or is at risk of being physically, emotionally or sexually abused, neglected or exploited you have a duty to report to one of the 53 Children's Aid Societies in Ontario. The requirement to file a report is outlined in the *Child and Family Services Act, 1990* as well as the *Regulated Health Professions Act, 1991*.

How do I maintain confidentiality?

If the report includes patient/client information then you should make your best effort to inform the patient/client prior to filing your report. If patient/client consent cannot be readily obtained, or is refused, your report should make this clear. Alternatively, you may choose to include the information with identifiers removed.

Failure to Submit a Report

Failure to submit a mandatory report of sexual abuse may result in a fine of up to $50,000 for an individual.

In instances where a mandatory report is not submitted, the failure to make the mandatory report may result in a referral of professional misconduct allegations to the Discipline Committee.

There are additional requirements for reporting other health care professionals if you operate a facility.

For additional information please refer to:

1. Mandatory Reporting by Employers/Facilities Fact Sheet
2. Sections 85.1-85.6 of the *Health Professions Procedural Code*

Resources

- *Regulated Health Professions Act, 1991*
- *Child and Family Services Act, 1990*
- *Retirement Homes Act, 2010*
- *Criminal Code of Canada, 1985*

- *Health Insurance Act, 1990*
- *Personal Health Information Protection Act, 2004*
- Retirement Homes Regulatory Authority
- Children's Aid Societies
- Children's Aid Societies
- Mandatory Reporting by Employers/Facilities Fact Sheet
- *Health Professions Procedural Code*

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COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Assessing Suitability to Practise Policy**

Number: **RG-Assessing Suitability to Practise-427**

Date originally approved: **September 25, 2015**

Date(s) revision approved:

BACKGROUND

Through the registration renewal process, (or at any other time during the year when change(s) occur), Members are required to provide information that demonstrates their continued suitability to practise[i]. For example, Members must declare to the CRTO annually if their employers have taken any disciplinary action against them. In essence, these declarations act as a continuation of the good character provisions that apply to applicants.

This policy outlines the criteria that the CRTO may use to determine if information reported by a Member, related to his/her conduct, appears to be relevant to the individual's suitability to practise.

POLICY

In accordance with S.54 of the Registration Regulation[ii] and CRTO By-Laws[iii] and Policies made pursuant to clause 94(1)(l.3) of the Health Professions Procedural Code, a Member is required to report within 30 days,

i. when charged or found guilty of an offence, ,
   a. under the *Criminal Code of Canada*,
   b. under the *Health Insurance Act,*
   c. under the *Controlled Drugs and Substances Act*,
   d. relating to prescribing, compounding, dispensing, selling or administering drugs,
   e. that occurred while practising respiratory therapy,
   f. in which s/he was impaired or intoxicated, or
   g. any other charge or offence relevant to the member's suitability to practise the profession;
ii. findings of professional negligence or malpractice;
iii. information regarding professional registration or conduct, including:
   a. if the Member has been disciplined, suspended, required to resign or terminated by his/her place of employment,
   b. if the Member has been the subject of any professional misconduct, incompetence or incapacity investigation or proceeding in Ontario or another jurisdiction, whether relating to Respiratory Therapy or not, and;
iv. any event, circumstance, condition or matter not disclosed by the above criteria that is relevant to his/her competence, conduct or physical or mental capacity that may affect his/her ability or suitability to practise as a Respiratory Therapist.

When the CRTO receives such a report, the Registrar will review the information provided by a Member and determine if any further investigation is required. The Member may be asked to provide additional information (e.g., for the contact information of the police officer or Crown attorney who knows most about the matter).

To determine whether an offence charge or finding is relevant to the Member's suitability to practise, the Registrar will consider relevant factors, including:

1. **Could the conduct that led to the charge or finding reasonably be seen to put the public at risk?**

   Elements that may be taken into consideration include:
   - degree of dishonesty or breach of trust,
   - motivation,
   - duration,
   - isolated or repeated incident (e.g., prior history),
   - concealment,
   - whether the offence was one in which the Member was impaired or intoxicated,
   - is the matter an issue of capacity?

2. **Has the Member expressed remorse?**
   - Member submission or explanation,
   - external verification (e.g., employer, character witness(es)).

3. **What has the Member done to address the conduct?**
   - treatment (e.g., rehabilitation),
   - education or remediation,
   - continued to work with no similar incidents reported.

4. **What has the Member's subsequent conduct been?**
   - absence of subsequent wrongdoing,
   - observations and references of those working in direct contact (especially those who are not friends, or have a duty to be candid),

If the Registrar believes, based on the above criteria, that the Member:

i. may not be mentally competent to practise Respiratory Therapy,
ii. may not practise Respiratory Therapy with decency, integrity and honesty and in accordance with the law, or
iii. may not display an appropriately professional attitude,

then further action will be required. Should the Registrar believe on reasonable and probable grounds[iv] that the Member has committed an act of professional misconduct, or is incompetent, s/he will request that the Inquiries, Complaints and Reports Committee appoint an investigator.

In general, the Registrar will only seek the appointment of an investigator if it appears that the conduct is relevant to a Member's ability to practice Respiratory Therapy ethically, safely and competently. Refer to Article 31 of the CRTO By-Laws for specific information regarding decisions of the Inquiries, Complaints and Reports Committee that will be included on the Register. If the Registrar believes the Member may be incapacitated then s/he will make inquiries pursuant to section 57 of the *Health Professions Procedural Code*.

[i] O.Reg 596/94 Part VIII, Ss.53(1)
[ii] Ibid.
[iii] CRTO By-Law 22-2015, Article 31
[iv] CRTO Policy CD-150 (Registrar's Reasonable and Probable Grounds)

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Determining Applicants' Suitability to Practice**

Number: **RG-Determining Good Character-422**

Date originally approved: **December 1, 2011**

Date last revision approved: **December 6, 2019**

POLICY

Determining Suitability to Practice

The Registration Regulation requires that an applicant for registration satisfies the following requirements:

> **53.** (1) An applicant for a certificate of registration of any class must satisfy the following requirements:
>
> 1. The applicant must fully disclose details of any criminal offence of which the applicant has been found guilty, including any offence under the *Controlled Drugs and Substances Act* (Canada) or the *Food and Drugs Act* (Canada).
> 2. The applicant must fully disclose details of every professional misconduct, incompetence, incapacity or other similar proceeding that he or she is the subject of and that relates to his or her registration or licensure in Ontario in another profession or in another jurisdiction in respiratory therapy or another profession.
> 3. The applicant must fully disclose details of every finding of professional misconduct, incompetence, incapacity or other similar finding that he or she previously has been the subject of while registered or licensed in Ontario in another profession or in another jurisdiction in respiratory therapy or another profession.
> 4. The applicant's past and present conduct afford reasonable grounds for belief that the applicant,
>
> i. is mentally competent to practise respiratory therapy,
>
> ii. will practise respiratory therapy with decency, integrity and honesty and in accordance with the law, and
>
> iii. will display an appropriately professional attitude. (O. Reg 596/94 s. 53)

Collectively, these are known as the "suitability to practice" requirements. The purpose of these requirements is to ensure that members of the CRTO will provide safe and ethical care to their patients/clients.

If the Registrar has concerns about an applicant's suitability to practice respiratory therapy, the Registrar will refer the applicant to the Registration Committee for consideration. In the regulation, the suitability to practice requirement is exemptible, meaning that if the person does not meet the requirement then the CRTO has some discretion in determining if the person should be registered, or registered with restrictions.

This policy outlines the criteria that the Registration Committee may use to determine if information reported by an applicant, related to their conduct, appears to be relevant to the individual's suitability to practise.

CONSIDERATIONS

1. Nature of the misconduct.

The applicant:

a) Has been charged or found guilty of an offence:

i. under the *Criminal Code of Canada*;

ii. under the *Health Insurance Act*;

iii. under the *Controlled Drugs and Substances Act*;

iv. relating to prescribing, compounding, dispensing, selling or administering drugs;

v. that occurred while the applicant was practising respiratory therapy;

vi. in which the applicant was impaired or intoxicated, or;

vii. any other charge or offence relevant to the applicant's suitability to practice[i] the profession.

b) Has been found guilty of professional negligence or malpractice (in any health field);

c) Has been disciplined, suspended, required to resign, terminated or subjected to similar action at their place of employment or in relation to a contract of service;

d) Is the subject of or has been the subject of a disciplinary, professional misconduct, incompetence, incapacity or similar proceeding, finding or investigation by a professional licensing or registration body.

The Registration Committee may also consider any other event, circumstance, condition or matter not disclosed by the above criteria that is relevant to the applicant's competence, conduct or physical or mental capacity that may affect his or her ability or suitability to practise as a Respiratory Therapist.

2. **Does the applicant's conduct reflect on his/her suitability to be a member of the CRTO?**

   Elements that may be taken into consideration include:

   - Degree of dishonesty or breach of trust
   - Motivation
   - Duration
   - Isolated or repeated incident (e.g., prior history)
   - Concealment
   - Whether the offence was one where the applicant was impaired or intoxicated
   - Is the matter an issue of capacity?

3. **Has the applicant expressed remorse?**

   - Applicant's submission or explanation
   - External verification (e.g., employer, character witness)

4. **What has the applicant done to address the conduct?**

   - Treatment (e.g., rehabilitation)
   - Education or remediation
   - Continued to work with no similar incidents reported

5. **What has the applicant's subsequent conduct been?**

   - Absence of subsequent wrongdoing
   - Observations and references of those working in direct contact (especially those who are not friends and have a duty to be candid)

INFORMATION REQUIRED

- Detailed information regarding the applicant's conduct. For example,
  a. Information related to charges
     i. the fact and content of the charge;
     ii. where applicable bail conditions, and;
     iii. where known the date and outcome of the charge(s)
  b. Information related to findings of guilt:

i. the date and a summary of the finding;

ii. the date and the sentence imposed, if any; and

iii. where the finding is under appeal, a notation to that effect.

c. Information related to professional negligence or malpractice;

i. the nature of, and a description of the finding including a copy of any written decision or reasons provided for the determination;

ii. the date that the finding was made;

iii. the name and location of the court that made the finding; and

iv. the status of any appeal initiated respecting the finding.

- Explanation of applicant
- Information from other sources:
  - directly from employer(s)
  - directly from regulator(s)
  - current police check
  - investigations
- Details of any actions taken to address the misconduct/incident

REGISTRATION COMMITTEE DECISIONS After considering the application and the factors set out above, a panel of the Registration Committee may:

- Direct the Registrar to register the applicant;
- Direct the Registrar to register the applicant with terms, conditions and limitations (for example, practise under supervision with frequent employer reports; anger management; professional ethics or boundaries course; mentoring)
- Request additional information
- Direct the Registrar to refuse to register the applicant.

[i] See CRTO Policy RG-427 (Assessing Suitability to Practise) for additional information.

Attached is the new Determining Applicants' Suitability to Practise fact sheet for reference. This fact sheet has been redeveloped from the Determining Applicants' Suitability to Practice policy to guide the applicants and the Registration Committee when considering an applicants' suitability to practice, as noted in Appendix H.

Overview

At times, an applicant for registration may disclose information to the College of Respiratory Therapists of Ontario (CRTO) that outlines concerns regarding their conduct or appears to be relevant, to their suitability to practice. The Registrar will review the application, and if the Registrar has concerns about an applicant's suitability to practice Respiratory Therapy, the Registrar will refer the applicant to a panel of the Registration Committee for consideration.

This fact sheet outlines the criteria that a panel of the Registration Committee may use to determine if the information disclosed by an applicant identifies concerns regarding their conduct or appears to be relevant to the applicant's suitability to practice.

Registration Regulation (Ontario Regulation 596/94, Part VIII)

Section 53(1) of the *Registration Regulation (O. Reg 596/94, PART VIII)* requires that an applicant for a certificate of registration satisfy several requirements. Collectively, these are known as the "suitability to practice" requirements. If the applicant does not meet these requirements, then a panel of the Registration Committee has some discretion in determining if the applicant should be registered or registered with restrictions. The purpose of these requirements is to ensure that members of the CRTO will provide safe and ethical care to their patients/clients.

The applicant must:

1. Fully disclose the details of any criminal offence they have been found guilty of.
2. Fully disclose the details of all professional misconduct, incompetence, incapacity, or other similar proceedings that they are the subject of and relates to their registration in Ontario from another jurisdiction in Respiratory Therapy or another profession.
3. Fully disclose the details of all previous findings of professional misconduct, incompetence, incapacity, or other similar findings they have been the subject of while in Ontario or another jurisdiction.
4. Satisfy that their past and present conduct afford reasonable grounds for belief that the applicant,
    a. is mentally competent to practise the profession;
    b. will practise with decency, integrity, and honesty, and in accordance with the law, and
    c. will display an appropriately professional attitude.

Under *section 53(2)*, any false or misleading statements/representation in the application will deem the applicant to have not satisfied the certificate of registration requirements. In addition, under *section 52(2)*, if the applicant is found guilty of an offence or becomes the subject of a preceding or finding shall immediately inform the registrar.

For a list of the full requirements please see the *Respiratory Therapy Act, (O. Reg. 596/94) s. 52 and s. 53.*

Considerations of the Registration Committee

1. **Nature of the misconduct**
   The Registration Committee considers the nature of the misconduct including charges, findings of guilt, professional negligence or malpractice, employer discipline, suspensions, terminations, etc., or subject of professional misconduct, incompetence, incapacity or similar proceeding, finding, or investigation by a professional licensing or registration body.

   The Committee may also consider any other event, circumstance, condition, or matter not disclosed by the above criteria that are relevant to the applicant's competence, conduct, or physical or mental capacity that may affect their ability or suitability to practice as a Respiratory Therapist.

2. **Does the applicant's conduct reflect their suitability to be a member of the CRTO?**
   I.e., Elements that may be taken into consideration include the degree of dishonesty or breach of trust, motivation, duration, isolated or repeated incident, concealment, was applicant impaired or intoxicated, is the matter an issue of capacity, etc.

3. **Has the applicant expressed remorse?**
   I.e., Applicant's submission/explanation, external verification, such as employer verification/character witness.

4. **What has the applicant done to address the conduct?**
   I.e., Treatment (such as rehabilitation), education or remediation, continued to work with no similar incidents reported.

5. **What has the applicant's subsequent conduct been?**
   I.e., Absence of subsequent wrongdoing, observations and references of those working in direct contact (especially those who are not friends and have a duty to be candid).

Information Required

When an applicant applies for a certificate of registration, a panel of the Registration Committee may require additional information to properly assess the application. This could include, but is not limited to:

- Facts and content of charges, any bail conditions, dates, and outcomes of **charges**;
- Date, a summary of **findings of guilt**, any sentences imposed, and if any findings are under appeal;
- Description and nature of **professional negligence or malpractice** findings with a copy of any written decisions or reasons provided for the determination, applicable dates, name and location of the court, and status of any appeals;
- Explanation from the applicant;
- Information directly from other sources including employer(s), regulator(s), health care practitioners, current police check and investigation; and
- Details of any actions taken to address the misconduct/incident.

Registration Committee Decisions

After considering the application and any information submitted by the applicant, a panel of the Registration Committee may direct the Registrar to:

- Register the applicant;
- Register the applicant with terms, conditions, and limitations (e.g., practise under supervision with employer reports; professional ethics or boundaries course; mentoring);
- Request additional information; or
- Direct the Registrar to refuse to register the applicant.

Resources

- Referral to the Registration Committee
- Registration requirements and how to meet them
- *Respiratory Therapy Act, Ontario Regulation 596/94* (O. Reg. 596/94): General
- *Respiratory Therapy Act, (O. Reg. 596/94) s. 53(1)*: Requirements for the Issuance of Certificates of Registration, Any Class

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COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

Title: **Terms Conditions and Limitations Policy**	Number: **RG-TCL-415**
Date originally approved: **May 21, 2009**	Date(s) revision approved: **September 26, 2014**

BACKGROUND

Members of the CRTO may have terms, conditions, and/or limitations imposed on their certificates of registration. These may be imposed by regulation or by one of the CRTO's statutory committees.

CONDITIONS IMPOSED BY REGULATION

Under the *Registration Regulation* (s. 54), **every certificate of registration** is subject to the following conditions:

1. The member shall provide to the Registrar at the first reasonable opportunity of the details of any of the following that relate to the member and that occur or arise after the registration of the member,

    i. a finding of guilt relating to any offence,

    ii. a finding of professional misconduct, incompetence, incapacity or other similar finding in Ontario in relation to another profession or in another jurisdiction in relation to respiratory therapy or another profession,

    iii. a proceeding for professional misconduct, incompetence, incapacity or other similar proceeding in Ontario in relation to another profession or in another jurisdiction in relation to respiratory therapy or another profession.

2. The member must maintain professional liability insurance in the amount and in the form as required under the by-laws.

3. The member must provide information about himself or herself in the manner and in the form as required under the by-laws.

4. The member must pay any fees required under the by-laws.

General Certificate of Registration

Under the *Prescribed Procedures Regulation* (s. 49 (1)) it is a condition of a General Certificate of Registration that a member not perform an advanced procedure unless the member has, within two years before the procedure is performed, successfully completed a certification process or program approved by the Registration Committee of the CRTO.

Under the *Prescribed Substances Regulation* (s. 49 (1)) a member holding a general certificate of

registration is authorized, in the course of engaging in the practice of the profession, and subject to the terms, conditions and limitations imposed on his or her certificate of registration, to administer therapeutic oxygen by inhalation.

Under the *Controlled Acts Regulation* (s. 14) a member of the College of Respiratory Therapists of Ontario who holds a General Certificate of Registration may perform:

- a tracheostomy tube change for a stoma that is more than 24 hours old. O. Reg. (87/14, s. 1.); and
- a tracheostomy tube change for a stoma that is less than 24 hours old. O. Reg. (87/14, s. 1).

if the procedure is ordered by:

(a) a member of the College of Physicians and Surgeons of Ontario, the College of Midwives of Ontario or the Royal College of Dental Surgeons of Ontario; or

(b) a member of the College of Nurses of Ontario who holds an extended certificate of registration under the Nursing Act, 1991. O. Reg. 87/14, s. 1.

Graduate Certificate of Registration

Under the *Registration Regulation* (s. 60 (1)) a Member registered with a **Graduate Certificate of Registration** shall,

1. at the first reasonable opportunity, advise every employer of any terms, conditions and limitations that apply to the member's graduate certificate of registration if their employment is in the field of respiratory therapy;
2. 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, the member holding the graduate certificate has reasonable grounds to believe, 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 minutes notice; and
3. not delegate a controlled act.

Under section 60 (2) of the *Registration Regulation* a Graduate Certificate is deemed to have been revoked 18 months after its (initial) date of issue.

Under the *Prescribed Procedures Regulation* (s. 49 (2)) it is a condition of a Graduate Certificate of Registration that a member not perform an advanced procedure below the dermis.

Under the *Prescribed Substances Regulation* (s. 49 (2)) it is a condition of a Graduate Certificate of Registration that the member not administer a prescribed substance by inhalation in the course of engaging in the practice of the profession.

Under the *Controlled Acts Regulation* (s. 14) a member of the College of Respiratory Therapists of Ontario who holds a Graduate Certificate of Registration may perform a tracheostomy tube change for a stoma that is more than 24 hours old. O. Reg. (87/14, s. 1.) if the procedure is ordered by:

> (a) a member of the College of Physicians and Surgeons of Ontario, the College of Midwives of Ontario or the Royal College of Dental Surgeons of Ontario; or
>
> (b) a member of the College of Nurses of Ontario who holds an extended certificate of registration under the Nursing Act, 1991. O. Reg. 87/14, s. 1.

Under the *Controlled Acts Regulation* (s. 14), it is a condition of a Graduate Certificate of Registration that the member not perform a tracheostomy tube change for a stoma that is less than 24 hours old.

Limited Certificate of Registration:

Under the *Prescribed Procedures Regulation*, section 49 (3), the following are conditions of a limited certificate of registration:

1. A member shall not perform an advanced procedure.
2. A member shall not perform a basic procedure unless the member is permitted to perform the procedure by the terms and conditions of his or her certificate of registration.

Under the *Prescribed Substances Regulation* (s.14.1(2)), a member who holds a Limited Certificate of Registration shall not administer a prescribed substance by inhalation in the course of engaging in the practice of the profession.

Under the *Controlled Acts Regulation* (s.14) a member who holds a Limited Certificate of Registration may perform a tracheostomy tube change for a stoma that is more than 24 hours old, as long as the performance of the procedure is permitted by the terms and conditions of his or her certificate of registration, and if the procedure is ordered by:

> (a) a member of the College of Physicians and Surgeons of Ontario, the College of Midwives of Ontario or the Royal College of Dental Surgeons of Ontario; or
>
> (b) a member of the College of Nurses of Ontario who holds an extended certificate of registration under the Nursing Act, 1991. O. Reg. 87/14, s. 1.

Under the *Controlled Acts Regulation* (s. 14), it is a condition of a Limited Certificate of Registration that the member not perform a tracheostomy tube change for a stoma that is less than 24 hours old.

Inactive Certificate of Registration

Under the *Registration Regulation* (s.63) it is a condition of an **Inactive Certificate** or Registration

that the member 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.

Terms, conditions and limitations imposed by regulation cannot be varied.

CONDITIONS IMPOSED BY THE REGISTRATION COMMITTEE

An application for a Certificate of Registration may be referred to a Panel of the Registration Committee if the Registrar is of the view that the applicant does not meet the CRTO's registration requirements or is of the opinion that terms conditions and limitations should be imposed on the certificate of registration. In general terms, such restrictions are imposed by a Panel of the Registration Committee in order to protect the public. Reasons for placing terms, conditions and limitations on a Member's certificate of registration include the following.

To ensure that, prior to practising without restrictions:

- the Member completes refresher/re-training;
- the Member's competence is demonstrated;
- the Member's competence is assessed;
- the Member practises under supervision.

Applications to Change Terms, Conditions and Limitations Imposed by an Order of the Registration Committee

Sections 19 (7) and (8) of the *Regulated Health Professions Act , 1991* (effective June 4, 2009) state that that a Member whose certificate of registration has terms, conditions and limitations imposed by the Registration Committee, cannot ask for them to be removed or modified within six (6) months of the original order without the prior permission of the Registrar.

POLICY

A Member may apply that the terms conditions and limitations imposed on his or her certificate of registration be removed or revised by a Panel of the Registration Committee. However, the Member cannot submit his or her application within six months of the original order's date without permission of the Registrar.

Applications made within six months of the original order's date will be reviewed by the Registrar. If the Registrar believes that there is substantial evidence to support the Member's application (e.g., the Member has undergone appropriate re-training and that his or her competence has been assessed), the Registrar may refer the Member's application to a Panel of the Registration Committee.

To request the removal or revision of the terms conditions and limitations imposed on a Member's certificate of registration by a Panel of the Registration Committee, a Member of the CRTO must submit an application to vary terms conditions and limitations to the Registrar.

The Member should provide evidence of competence in performing of a particular activity. This may include:

- A letter from a supervisor;
- Detailed list of activities performed under supervision, signed by the supervising health care professional(s);
- Evidence that the Member took upgrading/refresher courses.

The Registrar will notify the Member of the Registration Committee Panel review date. The Panel of the Registration Committee will review the documents provided and may:

- Remove the terms, conditions and/or limitations imposed on the Certificate of Registration
- Revise the terms, conditions and/or limitations imposed on the Certificate of Registration;
- Request more information from the Member;
- Refuse to remove or revise any of the terms, conditions and/or limitations imposed on the Certificate of Registration.

Notes: This policy does not apply to the standard conditions imposed by regulation on Graduate Certificates of Registration.

This policy also applies to individuals who had terms, conditions and limitations imposed prior to June 4, 2009.

Attached is the new Terms, Conditions and Limitations (TCL) fact sheet for reference. This fact sheet has been redeveloped from the TCL policy to providing resources for members who are seeking to vary/lift the TCLs imposed on their certificate of registration by the Registration Committee, the policy referenced is Appendix I.

Overview

This fact sheet provides resources for members of the College of Respiratory Therapists of Ontario (CRTO) who are seeking to vary/lift the terms, conditions, and limitations (TCLs) imposed by the Registration Committee on their certificate of registration.

TCLs on a member's certificate of registration imposed by specific regulations, such as the *Controlled Acts Regulation*, *Prescribed Procedures Regulation*, the *Respiratory Therapy Act* cannot be varied.

It is important to note that the information below is intended to provide a summary of the Terms, Conditions and Limitations. However, it is important to directly reference the relevant legislation (see Resources below), as a complete and accurate source of the requirements expected of the contents of terms, conditions and limitations requirements.

Conditions Imposed by Regulation

General Certificate of Registration

The conditions imposed on a **General Certificate of Registration** in regulations are:

1. *Prescribed Procedures Regulation* (s. 49 (1))
    - It is a condition that a member holding a General Certification of Registration does not perform an advanced procedure unless they have successfully completed a certification process or program approved by the CRTO's Registration Committee within two years prior to the procedure being performed.
    - A member holding a General Certificate of Registration while engaging in the practice of Respiratory Therapy, is authorized to administer therapeutic oxygen by inhalation providing there are no terms, conditions and limitations prohibiting it.

2. *Controlled Acts Regulation* (s. 14)
    - A member holding a General Certificate of Regulation may perform a tracheostomy tube change for a stoma that is:
        i. More than 24 hours old; and/or
        ii. Less than 24 hours old if the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario, or the College of Midwives of Ontario, or the Royal College of Dental Surgeons of Ontario or the College of Nurses of Ontario (if they hold an extended certificate of registration under the *Nursing Act, 1991*.

Graduate Certificate of Registration

The conditions imposed on a **Graduate Certificate of Registration** in regulations are:

1. *Registration Regulation* (s. 60 (1))
    - If a member is working in Respiratory Therapy, they must advise all employers of any terms, conditions and limitations that apply to their Graduate Certificate of Registration;
    - A member holding a Graduate Certificate of Registration can only perform a controlled act, authorized to the profession, under general supervision with a member of the CRTO that the graduate member has reasonable grounds to believe is authorized to perform the controlled act, is personally competent to do so, and who is available to be personally present at the site where the authorized act is performed on ten minutes notice; and
    - A member holding a Graduate Certificate of Registration cannot delegate a controlled act.

2. *Prescribed Procedures Regulation* (s. 49 (2))
    - A member holding a Graduate Certificate of Registration cannot perform an advanced prescribed procedure below the dermis.

3. *Prescribed Substances Regulation* (s. 49 (2))
    - A member holding a Graduate Certificate of Registration cannot administer a prescribed substance by inhalation while engaging in the practice of Respiratory Therapy.

4. *Controlled Acts Regulation* (s. 14)
    - A member holding a Graduate Certificate of Registration may perform a tracheostomy tube change for a stoma that is more than 24 hours old if the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario, or the College of Midwives of Ontario, or the Royal College of Dental Surgeons of Ontario or the College of Nurses of Ontario (if they hold an extended certificate of registration under the *Nursing Act, 1991*.
    - A member holding a Graduate Certificate of Registration cannot perform a tracheostomy tube change for a stoma that is less than 24 hours old.

Please note: A Graduate Certificate expires **18 months after** its initial date of issue under section 60 (2) of the *Registration Regulation*.

Limited Certificate of Registration

The conditions imposed on a **Limited Certificate of Registration** in regulations are:

1. *Prescribed Procedures Regulation* (s. 49 (3))
    - A member holding a Limited Certificate of Registration cannot perform an advanced prescribed procedure.
    - A member holding a Limited Certificate of Registration cannot perform a basic procedure unless the member is permitted to perform the procedure by the terms and conditions of their certificate of registration.

2. *Prescribed Substances Regulation* (s. 14.1 (2))
    - A member holding a Limited Certificate of Registration cannot administer a prescribed substance by inhalation while engaging in the practice of Respiratory Therapy.

3. *Controlled Acts Regulation* (s. 14)
    - A member holding a Limited Certificate of Registration may perform a tracheostomy tube change for a stoma that is more than 24 hours old if the procedure is permitted by the terms, conditions and limitations of their certificate or registration, and is ordered by a member of the College of Physicians and Surgeons of Ontario, or the College of Midwives of Ontario, or the Royal College of Dental Surgeons of Ontario or the College of Nurses of Ontario (if they hold an extended certificate of registration under the *Nursing Act, 1991*).
    - A member holding a Limited Certificate of Registration cannot perform a tracheostomy tube change for a stoma that is less than 24 hours old.

Inactive Certificate of Registration

The conditions imposed on an **Inactive Certificate of Registration** in regulations are:

1. *Registration Regulation* (s.63)
    - A member holding an Inactive Certificate of Registration cannot engage in direct patient care, use any title or designation listed in the Table of section 67, supervise the practice of the profession, or make any claim or representation to having any competence in the profession.

Conditions Imposed by the Registration Committee

Often, an application for a certificate of registration may be referred to a panel of the Registration Committee if the Registrar believes that the applicant does not meet the CRTO's registration requirements or believes that TCLs should be imposed on the certificate of registration. These restrictions are imposed by the panel of the Registration Committee to protect the public.

Requests to Lift / Modify Existing TCLs

A member of the CRTO may apply to have the TCLs that are imposed on their certificate of registration removed or revised by a panel of the Registration Committee. To request to have TCLs removed or revised, the member must submit an application for change to terms, conditions and limitations to the Registrar. Applications will be considered by the Registrar under s. 19 of the *Regulated Health Professions Act, schedule 2, Health Professions Procedural Code* (the "*Code*").

Application for Change

A member may apply to the Registration Committee for an order directing the Registrar to remove or modify any term, condition or limitation imposed on the certificate of registration because of a registration proceeding.

Once a decision has been made on an application under this section, the applicant may not make a new application within six months without the approval of the Registrar.

Applications to change terms, conditions and limitations that are made within six (6) months of the original TCL's order date will be reviewed by the Registrar. If the Registrar believes that there is substantial evidence to support the member's application (e.g., the member has undergone appropriate re-training and that their competence has been assessed), the Registrar may refer the application to a panel of the Registration Committee for review.

Submission

In addition to the Application for Change to Terms, Conditions, and Limitations, the member should also provide evidence of competence in performing a particular activity, this may include:

- A letter from a supervisor;
- A detailed list of activities performed under supervision, signed by the supervising health care professional(s);
- Evidence that the member took upgrading/refresher courses.

Review and Decision of the Registration Committee

Once an application to change terms, conditions and limitations have been referred to the Registration Committee for consideration CRTO staff will notify the member of the Panel review date. The Panel of the Registration Committee will review the documents provided and decisions may include:

- Remove the TCLs imposed on the Certificate of Registration
- Revise the TCLs imposed on the Certificate of Registration
- Request more information from the Member
- Refuse the application

Resources

- Application to Change Terms, Conditions, and Limitations
- Guide for Terms, Conditions, and Limitations (TCLs) imposed by the Registration Committee
- Registration and Use of Title Professional Practice Guideline
- Interpretation of Authorized Acts

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
General Email: questions@crto.on.ca

AGENDA ITEM 8.1 **September 24, 2021**

From:	*Executive Committee*
Topic:	*Council Dates 2022*
Purpose:	*For Information*
Strategic Focus:	*Enhancing College Governance*
Attachment(s):	

RECOMMENDATION:

That the following dates be selected for 2022 Council meetings:

March 4, 2022

May 27, 2022

September 23, 2022

December 2, 2022