December 2023

Abuse Awareness & Prevention

PROFESSIONAL PRACTICE GUIDELINE

Professional Practice Guideline

College of Respiratory Therapists of Ontario (CRTO) publications contain practice parameters and standards that 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.

Resources and references are hyperlinked for convenience and referenced to encourage exploration of information related to individual areas of practice and/or interests. **Bolded** terms are defined in the Definitions.

It is important to note that employers may have policies related to abuse awareness and prevention. If an employer's policies are more restrictive than the CRTO's expectations, the RT must abide by the employer's policies. Where an employer's policies are more permissive than the expectations of the CRTO, the RT must adhere to the expectations of the CRTO.

The CRTO will update and revise this document every five years, or earlier if necessary.

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Introduction

The ***Regulated Health Professions Act*** (RHPA) along with Schedule 2 to the RHPA, the Health Professions Procedural Code (Code) requires that all health regulatory Colleges in Ontario have measures for preventing and dealing with the sexual abuse of patients/clients and to encourage the reporting of such abuse. Although this provision in the RHPA specifically addresses the prevention of sexual abuse, all Respiratory Therapists ~~s~~hould note that any form of abuse (e.g., sexual, verbal, physical, emotional, financial) is not tolerated and would be considered professional misconduct by the College of Respiratory Therapists of Ontario (CRTO). This practice guideline will differentiate between sexual abuse and other forms of abuse. A section of this practice guideline will also discuss the effect of the *Child and Family Services Act* on Respiratory Therapy practice.

This guideline is divided into three primary sections:

1. **Abuse Awareness** – understanding the needs of patients/clients who have experienced, or are experiencing, some form of violence.

2. **Abuse Prevention** – ensuring that RTs do not commit any manner of abuse or harassment, and that they report abuse when it occurs.
    - **Professional Conduct** - expectations of Respiratory Therapists (RTs) within their therapeutic and professional relationships.

3. **Members' Responsibilities Regarding Abuse Prevention** – reporting obligations, penalties for abuse.

Definitions

Abuse For the purposes of this practice guideline, unless otherwise indicated, abuse may be defined as **treating others in a harmful, injurious, or offensive way** and includes, but is not limited to:

- **Physical abuse** (e.g., pushing, shoving, shaking, slapping, hitting or other physical force that may cause harm);
- **Verbal abuse** (e.g., derogatory or demeaning comments, cultural slurs, use of profane language, insults);
- **Emotional abuse** (e.g., threats, intimidation, insults, humiliation and harassment);
- **Financial abuse/exploitation** (e.g., theft, forging a person's signature, influencing a patient/client to change their Will);
- **Cyber abuse** (e.g., cyber bullying by conveying inappropriate images and words through any form of electronic media); and
- **Sexual abuse/assault/harassment** (see sections on Sexual Abuse, Sexual Assault & Sexual Harassment).

Did you Know?

Unless the regulator has a spousal exception set out in regulation, when a registered Member of the profession treats their spouse, they contravene the sexual abuse provision in the RHPA, and can potentially face mandatory revocation of their certificate of registration.

For more information, please see the CRTO's Conflict of Interest PPG under "Treatment of a

Member Refers to a Respiratory Therapist who is, or was, registered with the CRTO.

Non-Patient/Client An individual who does not meet the definition of patient/client but who alleges sexual misconduct against a Respiratory Therapist. Examples include a Student Respiratory Therapist, family member of a patient/client, or other health care providers.

Patient/Client[1] For the purposes of the sexual abuse provisions of the RHPA an individual is considered a patient/client of the Member if there is a direct interaction between the Member and the individual and any of the following conditions are met:

a) The Member contributed to the individual's health record;

b) The Member charged or received payment for health services provided to the individual;

c) The individual consented to health services recommended by the Member; or

d) The Member prescribed a drug for the individual.

An individual is considered to be a patient/client of the Member for at least **one (1) year** after any of the above contacts.

[1] Regulation 206/18 under the RHPA lists specific criteria for the purposes of determining whether an individual is a patient of a member for the purpose of the sexual abuse provisions of the Code.

Did you Know?

Unless prescribed in regulation, when a registered Member of the profession treats their spouse, they contravene the sexual abuse provision in the RHPA, and can potentially face mandatory revocation of their certificate of registration.

For more information, please see the CRTO's Conflict of Interest PPG under "Treatment of a Spouse".

Sexual Abuse As defined in the *Code* sexual abuse means:

a) sexual intercourse or other forms of physical sexual relations between the member and the patient;

b) touching, of a sexual nature, of the patient by the member; or

c) behaviour or remarks of a sexual nature by the member towards the patient[2].

Sexual nature does not include touching, behaviour or remarks of a clinical nature that are appropriate for the professional service being provided[3].

Sexual Assault Conduct that amounts to sexual abuse pursuant to the Code may also constitute sexual assault in the criminal context. Certain situations can magnify the gravity of a sexual assault, such as when the assailant is in a position of trust or authority over the individual. Sexual assault is defined in the *Criminal Code of Canada* (CCC) as any form of sexual contact without both parties' voluntary consent[4]. According to the CCC, there is no consent if:

> *The accused counsels or incites the complainant to engage in the activity by abusing a position of trust, power or authority[5].*

"Sexual harassment is engaging in a course of vexatious comments or conduct that is known or ought to be known to be unwelcome" (Ontario Human Rights Code, 2013)

Sexual Harassment Common types of sexual harassment include:

1. **Threatening** – (e.g., threatening punishment or offering rewards in return for sexual favours)
2. **Physical harassment**
3. **Verbal harassment**

Sexual harassment can also take place virtually (i.e., cyber abuse) through such media as email and/or social media posts containing sexual content.

[2] *Regulated Health Professions Act, Health Professions Procedural Code, s.1(3)*. Retrieved from www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm

[3] *Regulated Health Professions Act*, *Health Professions Procedural Code*, s.1(4). Retrieved from www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm

[4] Government of Canada. (1985). *Criminal Code of Canada*, s. 153(2) (3). Retrieved from http://laws-lois.justice.gc.ca/eng/acts/C-46/

[5] Ibid.

4. **Non-verbal harassment** – (e.g., body language, sexual gestures)
5. **Environmental harassment** – (e.g., sexually suggestive pictures or objects in the workplace).

Sexual Misconduct Acts of sexual abuse, assault or harassment by a Respiratory Therapist the behaviour constitute Professional Misconduct [6].

[6] *Respiratory Therapy Act (1991),* O Reg 753/93 | Professional Misconduct

Abuse Awareness

It is important for all RTs to recognize that assault, harassment and sexual abuse[7] can be perpetrated against individuals from all cultures and economic backgrounds. The prevalence of abuse is such that a significant number of health care consumers are survivors of some form of interpersonal violence (abuse, sexual abuse/assault), and their past experiences may affect how they perceive the treatments provided to them.

Prevalence & Implications of Abuse

Accurate statistics on the prevalence of abuse, particularly sexual abuse, are difficult to obtain as only "about one in ten sexual assaults are reported to police"[8]. However, it is likely that health care practitioners will encounter survivors of sexual abuse/assault and other forms of abuse in their practice[9]. Research indicates (as of March 2023) that:

- Approximately 33% of women and 14% of men are survivors of childhood sexual abuse[10]; and
- Indigenous women were almost three times more likely than non-Indigenous women to report having been a victim of a violent crime, such as sexual assault[11].

The effects of abuse are far reaching and can severely impact an individual's emotional stability, physical health, and the ability to form and maintain adult relationships. A history of childhood sexual abuse or a range of childhood traumas is correlated with:

- greater use of medical services;
- substance abuse, self-mutilation, suicide; and
- ischemic heart disease, cancer, chronic lung disease[12].

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[8] Statistics Canada. (2008). *Sexual assault in Canada 2004 and 2007. (Canadian Centre for Justice Statistics Profile Series).* Retrieved from www.statcan.gc.ca/pub/85f0033m/85f0033m2008019-eng.pdf

[9] Public Health Agency of Canada. (2009). *Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse.* Ottawa, ON: Public Health Agency of Canada.

[10] *Ibid*.

[11] Statistics Canada. (2011). *Violent victimization of Aboriginal women in the Canadian provinces, 2009.* Retrieved from Juristat (statcan.gc.ca)

[12] Public Health Agency of Canada. (2009). *Handbook on Sensitive Practice for Health Care Practitioners: Lessons from* Adult Survivors of Childhood Sexual Abuse. Ottawa,ON: Public Health Agency of Canada.

Principles of Sensitive Professional Practice

The primary goal of Sensitive Practice is to facilitate feelings of safety for the client.

Procedures that may appear routine to the RT may be very traumatizing for abuse survivors, as it can cause them to feel exposed, vulnerable and powerless. ***The Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse*** outlines nine principles of sensitive practice that include respect, taking time, sharing information and respecting boundaries[13]. The primary goal of sensitive practice is to facilitate feelings of safety and control. The following should be taken into consideration during every patient/client interaction:

In Western culture, eye contact is generally interpreted as attentiveness and honesty. However, other cultures may perceive direct eye contact as being disrespectful or rude.

- Obtain consent at every stage of the procedure;
- Ensure the patient/client knows they can stop the procedure at any time;
- Allow as much time as needed for the patient/client interaction; and
- Be aware of potential triggers (e.g., exposing the chest, touching, inserting objects into the mouth).

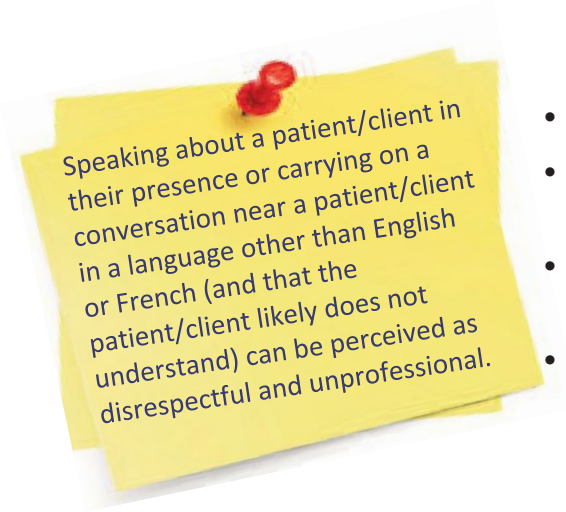
While providing care, RTs must respect their patient's/client's cultural diversity, sexual orientation and physical and intellectual differences.

Communication Principles

Communication occurs through words, body language and active listening. RTs can ensure that they practice in a sensitive manner by:

What a health care professional might view as "terms of endearment" such as "honey", "sweetie", "dear" can be interpreted by others as "terms of diminishment" (Ontario Human Rights Commission, 2013)

- Being aware of the communication needs and styles of others;
- Introducing themselves using their name and professional title (this also includes introducing any students or other staff members who may be present);
- Explaining the procedures carefully, choosing words that ensure the patients/clients understand what will be done and what is required of them;
- Obtaining consent (whenever possible) prior to touching patients/clients and informing them that they may withdraw their consent at any time;
- Speaking directly to patients/clients and maintaining culturally appropriate eye contact;



- Allowing the patients/clients opportunities to ask questions;
- Providing reassurance and explanations throughout the procedure;
- Asking for the patient's/client's consent for student or staff observation, assistance or performance of a procedure; and
- Refraining from making any sexually suggestive or other types of inappropriate comments (e.g., sarcasm, racial slurs, teasing, swearing).

Scenario

A physician obtains consent from a female patient/client for a Pulmonary Function Test (PFT). However, when she arrives for the test and the RT explains that she must put a device in her mouth and a have a clip put on her nose, the patient/client becomes agitated and refuses to have the test done.

What do you do?

It should be remembered that consent is a process, not a single event. Despite the best attempts to obtain prior informed consent, the patient/client may not fully anticipate how they might react to a test or procedure until they are actually in the situation. If it is an RT performing the task, then it is the RT who is responsible for ensuring that the patient/client understands that consent can be withdrawn at any stage of the interaction.

Touching Principles

Appropriate words, behaviour and touching can reduce the embarrassment, distress, and fear that some patients/clients experience when receiving care. Touching must be appropriate to the service the RT is providing. RTs can ensure that they practise in a sensitive manner by:

- Obtaining consent, whenever possible, prior to touching the patient/client;
- Allowing the patient/client to disrobe themselves and only touch body areas needed to facilitate removal of clothing when providing assistance to disrobe;

- Respecting the client and their personal space;
- Providing the patient/client with an opportunity to have another person present during the interaction;
- Respecting cultural diversity;
- Avoiding placing instruments or other materials on a patient/client; and
- Helping maintain the patient's/client's dignity wherever possible (e.g., use appropriate draping to provide privacy).

Scenario

A male RT is required to set and perform a Cardiac Stress Test (CST) on a female patient/client.

What do you do?

In this situation, if at all possible it is advisable to give the patient/client the choice of having another person in the room during the preparation phase. Many organizations also have a policy that deals with this type of patient/client interaction.

Time and space constraints, especially in an acute care setting, sometimes mean that things are done to and around a patient/client that would not normally occur in other person-to-person interactions (e.g., intubation equipment placed on patient's/client's chest, oxygen tanks placed between a patient's/client's legs). RTs must always do what is necessary in a given situation to provide the best possible care to their patient/client, while also respecting the patient's/client's personal space and autonomy.

Abuse Prevention

Preventing abuse is everyone's responsibility. If you are the subject of, or witness to, abuse you have a professional and ethical duty to report the behaviour. In addition, you may wish to consider the following recommendations:

- FIRMLY tell the person that their behaviour is not acceptable and ask them to stop. You can ask a supervisor or union member to be with you when you approach the person.
- KEEP a factual journal or diary of daily events. Record:
  - The date, time and what happened in as much detail as possible
  - The names of witnesses
  - The outcome of the event.
- KEEP copies of any letters, memos, emails, faxes, etc., received from the person.

Remember, it is not just the character of the incidents, but the number, frequency, and especially the pattern that can reveal the abuse or harassment.

REPORT the abuse to the person identified in your workplace policy, your supervisor, or a delegated manager. If your concerns are minimized, proceed to the next level of management. Consider reporting the individual to their regulatory College.

CRTO Zero Tolerance Position Statement

The CRTO's Zero Tolerance position statement regarding abuse states:

The College of Respiratory Therapists of Ontario (CRTO) recognizes the seriousness and extent of harm that sexual abuse and other forms of abuse can cause to individuals, their family members, and members of the healthcare team. Therefore, the CRTO has a position of zero tolerance for any form of abuse (sexual, physical, verbal, emotional, financial, or cyber) by its Members.

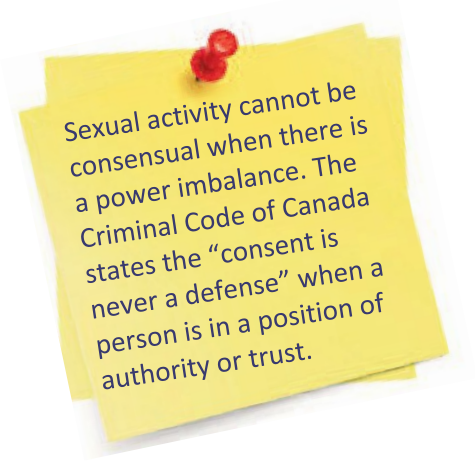
Through its standards of practice, policies and guidelines, the CRTO strives to educate its Members on the effects and/or impacts of **abuse**. The CRTO expects the principles of **sensitive practice** to be an important part of the care our Members provide. It is important for the profession to be aware of the imbalance of power that exists in various relationships.

The CRTO will ensure all Respiratory Therapists are aware that abuse in any form is unacceptable and will not be tolerated.

Please note that abuse in any form is considered to be professional misconduct and allegations of abuse will be referred to the Inquiries, Complaints and Reports Committee (ICRC).

Therapeutic & Professional Relationships

Most RTs engage in the following two key relationships when practicing the profession:



1. **Therapeutic Relationships** exists between patients/clients, their family members, substitute decision maker and/or guardians.
2. **Professional Relationships** exists between other members of the health care team, such as co-workers, colleagues and students.

Both types of relationships are built on trust, respect, compassion and honesty. RTs must always conduct themselves within these relationships in a manner that is free of all forms of abuse, including sexual abuse. The responsibility falls on the RT to know what meets the legal obligations and professional standards of acceptable conduct. Ignorance of these obligations or standards is not an acceptable defense. Professional standards regarding **Professional Boundaries / Therapeutic & Professional Relationships** are outlined in the CRTO **Standards of Practice - Standard 12**. RTs are also expected to adhere to their organizational policies regarding conduct.

Managing Power Imbalances

In both therapeutic and professional relationships, an inherent power imbalance exists that favours the RT (e.g., between RT and patient/client, between staff RT and student, etc.). This power imbalance occurs because the RT has authority, knowledge, access to information (including personal health information about a patient/client) and influence. This inequity can increase the potential for abuse and cannot be managed by obtaining consent[14].

[14] McPhedran, M., & Sutton, W. (2004). *Preventing Sexual Abuse of Patients: A Legal Guide for Health Care*

Therapeutic Relationships

Patients/clients depend on the unique knowledge and skills of RTs to provide them with the care they need. The power imbalance places the patient/client in a dependent position, and it is the responsibility of the RTs to ensure that a proper therapeutic relationship is established and maintained. To do so, RTs must respect the dignity and privacy of the patient/client and their cultural, religious and sexual diversity.

It is the expectation that RTs:

- recognize that an individual remains a patient/client for at least one year following their last professional interaction;
- not engage in behaviour, conversations, or make comments that cause discomfort to patients/clients;
- not engage in any sexual activity with a patient/client;
- not condone abusive behaviour of others by any means including words, actions, body language or silence;
- understand that patients are frequently in a vulnerable state and may not be able to advocate for themselves; and
- learn about attitudes and behaviours (e.g., cultural, religious, societal) that are appropriate to the patient/client services you provide.

To learn more about providing culturally competent care, please see the CRTO's Commitment to Ethical Practice.

Scenario

A male RT observes a colleague telling an inappropriate joke to a teenage patient. The RT doesn't laugh or take part in the joke but he also does not say anything to the colleague or the colleague's supervisor.

What do you do?

By his silence, the RT has given his unspoken approval for the colleague's behaviour and has done nothing to prevent this type of conduct in the future.

Professional Relationships

RTs often work within an interprofessional team and are required to use a wide range of communication and interpersonal skills to effectively establish and maintain professional relationships. In addition, RTs teach students, manage staff and take part in the administration of their organization. It is essential that RTs comply with the same standards for interactions in these professional relationships as they do in therapeutic relationships.

Scenario

An RT thinks that another health care professional with whom they work is lazy and argumentative, and doesn't hesitate to tell this to their peers in the lunchroom.

What do you do?

The CRTO Standards of Practice requires that RTs "refrain from maligning the reputation of any colleague." (CRTO Standards of Practice - Standard 12)

Professional Boundaries

Issues related to abuse, sexual abuse, sexual assault and sexual harassment can also arise for RTs outside of therapeutic relationships with patients/ clients. Just as in therapeutic relationships, professional relationships are based on trust and respect for boundaries. As outlined in the CRTO **Standards of Practice**, the RT is expected to appropriately manage these professional relationships by:

- collaborating and co-operating with peers and other health professionals in order to serve the best interest of their patients/clients; and
- maintaining clear and appropriate professional boundaries in all professional interactions.

Scenario

An RT sees a particular patient in the Asthma Clinic on a regular basis. They begin to interact on Facebook™ and then the patient/client starts calling the RT at her home seeking advice between visits.

What do you do?

In all patient/client – RT interactions, the RT is responsible for identifying and maintaining clear professional boundaries. It makes no difference if the patient/client agrees or even initiates the interactions. RTs should not engage with

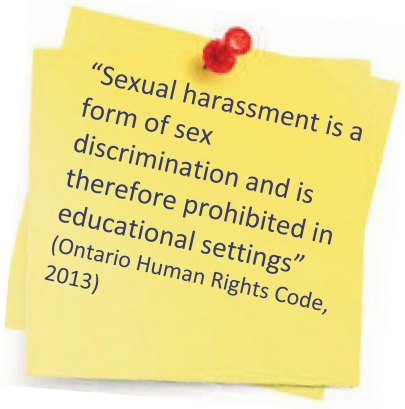
Please Note:

The ***Professional Misconduct Regulation*** (s.29) states that it is an act of professional misconduct for an RT to be:

"Engaging in conduct or performing an act, relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by Members as disgraceful, dishonorable or unprofessional."

Students

Student RTs (as well as other students that an RT may be teaching) are dependent on the RT for their training and for an unbiased evaluation. As a result, a power imbalance exists in both the school setting (RT professor to student) and in the clinical care setting (staff RT to student). It is important to understand that the role of the RT in these situations is solely to assist the student in gaining the knowledge, skills and abilities necessary to become a competent professional. Students also must understand that abuse of any form by an RT should not be tolerated. If a student feels they are being abused by an RT, the student should follow the process of their educational facility and also contact the CRTO.



Scenario

A staff RT is responsible for supervising an RT student and over a number of shifts they develop a friendly rapport. They begin following each other on Twitter and commenting on each other's tweets initially in a good-natured manner. After a few weeks, however, the RT's tweets become increasingly personal and full of innuendo. The student RT feels very uncomfortable with these interactions but is afraid to speak up or "unfollow" the RT for fear of offending them and jeopardizing their clinical rotation.

What do you do?

The person favored by the power imbalance, in this case, the staff RT, bears the responsibility for managing the professional relationship. Students are vulnerable because they are dependent on the RT for an unbiased evaluation that may not only impact their clinical rotation but also their future job prospects. Students are also at a disadvantage and are often hesitant to speak up because they are unsure of the cultural norms and expectations. The staff RT, in this scenario, is accountable for the relationship they have with the student.

Dating

Dating and other forms of affectionate behavior between an RT and their patient/client may constitute sexual abuse as defined by the RHPA. As discussed earlier in this document, the relationship between an RT and their patient/client has an inherent power imbalance.

There can be no sexual contact between an RT and their patient/client for a one-year period following the termination of the professional relationship. In some instances, it will never be appropriate to date a former patient (such as when the patient/client was particularly vulnerable). Once a patient/client is discharged from the hospital or **permanently** transferred to another RT, the waiting period is a minimum of one year before the patient/client and RT can enter into a sexual relationship. Waiting less than one year constitutes sexual abuse of a patient/client.

In addition to a power imbalance existing between an RT and a patient/client, a similar inequity exists between an RT and a Student Respiratory Therapist (SRT) where the RT is directly or indirectly supervising the student. As a result of the RT's status and influence over the SRT (being educated by the CRTO Member), an RT may not have a personal relationship with the SRT. Such a personal relationship is unprofessional conduct and may be considered sexual misconduct resulting in a public discipline hearing and onerous sanctions against the RT.

In general, RTs are advised to avoid personal relationships with anyone over whom they may be perceived to have professional influence (e.g., family members of patients/clients) for a minimum of one year following the end of professional practice interactions.

Scenario

An RT works at the pediatrics hospital and frequently speaks with the single father of a child she cares for in the Cystic Fibrosis (CF) Clinic. At one point, the father asks the RT if she would like to go for coffee sometime.

What do you do?

In this scenario, the father is not a patient/client of the RT. However, there is still a power imbalance because the father is dependent upon the RT for the care she provides to his child. The RT must refrain from developing a social relationship with the father until his child has been formally discharged from the CF Clinic.

Members' Responsibilities Regarding Abuse Prevention

Penalties for Abusing a Patient/Client

Abusing a patient/client is professional misconduct[15]. If there are allegations of abuse against an RT, they will be referred to ICRC and may be referred on to a Discipline hearing. Discipline proceedings are open to the public, and the outcome of them will be placed on the Public Register if there is a finding against the Member.

If a Member is found guilty of **professional misconduct** (abusing a patient/client; failing to file a report of abuse; contravening the RHPA, etc.), the panel of the Discipline Committee **may** take any one or more of the following actions [16]

1. Revocation of their certificate of registration
2. Suspension of their certificate of registration for a specified period of time
3. Imposition of specified terms, conditions and limitations on the Member's certificate of registration for a specified or indefinite period of time
4. A reprimand
5. A fine of not more than $35,000 payable to the Minister of Finance
6. An order requiring the Member to reimburse the College for sexual abuse therapy or counselling.
7. An order requiring the Member to post security acceptable to the College to guarantee the payment of monies for sexual abuse therapy or counseling.

For more frank acts of sexual abuse, the Code sets out a mandatory penalty of at least revocation and a reprimand.

[15] O.Reg 753/93 – Professional Misconduct section 5
[16] Health Professions Procedural Code (HPPC) s. 51(2)

Reporting Suspected Abuse

Suspected abuse by a health professional is difficult to deal with in any situation. It is an RT's ethical, professional, and sometimes legal responsibility to report any incidents of unsafe professional practice or professional misconduct (physical, verbal, emotional and/or financial abuse involving a regulated or non-regulated health care provider) to the appropriate authority.

The CRTO **Standards of Practice** states that an RT is accountable for the following:

- reporting sexual abuse of a patient/client by a regulated health professional to the appropriate College;
- reporting to the CRTO whenever their employment of a Member has been terminated for reasons of professional misconduct, incompetence or incapacity;
- reporting a Member of the CRTO to the College where they have reason to suspect incompetence, professional misconduct or incapacity; and
- reporting incidents of unsafe professional practice or professional misconduct; and
- reporting physical, verbal, emotional and/or financial abuse of a patient/client by a regulated or non-regulated health care provider to the appropriate authority.

Standard 13 – Professional Responsibilities

- Employers must report to the CRTO, in accordance with regulatory requirements, the following:
  1. whenever, for whatever reason of professional misconduct, incompetence or incapacity, they terminate, suspend or impose restrictions on the employment of a Member; and
  2. where they have reason to suspect a Member is incompetent, incapacitated, has sexually abused a patient/client or committed an act of professional misconduct.
- Report to relevant authorities of any unsafe practice, unprofessional conduct, or incapacity by other healthcare team members.
- Report to the appropriate authority the following:
  1. sexual abuse of a patient/client, student, other healthcare team member and/or
  2. verbal, emotional, psychological or physical abuse of a patient/client, student, other member of the healthcare team, or
  3. taking advantage of a patient/client or student as a result of the Member's position in the relationship.

In addition, the Code requires RTs to submit a report when they have reasonable grounds, obtained during the course of practising their profession, to believe that a Member of the CRTO or a different College has sexually abused a patient/client.

Under the Code, RTs must report sexual abuse, if any of the following apply:

1. *Where they have "reasonable grounds" to believe sexual abuse occurred* (For example, concrete information from a reliable source or a patient/client, as opposed to rumour); or
2. *Where they obtained the information concerning sexual abuse during the course of practising the profession* (The reporting requirement is not intended to capture information learned outside the patient care/employment setting); or
3. *When they know the name of the alleged abuser (member)* (You are not required to file a report if you do not know the name of the alleged abuser); or
4. *Where the alleged abuser is registered with one of the health regulatory Colleges* (If you are not sure, you can check with the College that regulates their profession); or
5. *Where the person being abused was a patient/client* (See the definition of "patient/client" on page 5); or.
6. *If the conduct involved sexual abuse as defined by the Code* (See the definition of "sexual abuse" on page 6).

Any questions regarding the reporting requirements and process can be directed to the CRTO.

Although there is no obligation under the RHPA to report sexual abuse of non-patients, (e.g. co-workers or students) there is a **professional obligation** to report another Member of the CRTO where there is reason to suspect professional misconduct. (CRTO Standards of Practice - Standard 13)

A report must be filed with the Registrar of the appropriate College within 30 days of the incident being brought to the RT's attention, unless the RT reasonably believes the abuser will continue to abuse, in which case they must file the report immediately. The report must be in writing and include:

- the RT's name, address, and a phone number where they can be reached
- the name of the alleged abuser (regulated health care professional);
- details/description of the alleged abuse;

- the name of the patient/client, only if the patient/client consents, in writing, to their name being included (if the patient will not give consent you must still submit the report but do not include the patient/client's name. You should include the fact that you have tried to obtain consent, and that it was refused, in the report);
- the names of witnesses or any other persons who might have information about the alleged abuse is also helpful.

The following tips will help you assist someone if they tell you they have been abused:

DO:	DON'T
• Listen calmly and with an open mind. • Take the information seriously. • Reassure the person that they are not to blame, and that they are not alone. • Be supportive. • Involve the appropriate institutional staff, while respecting the person's privacy. • Report the incident to the Registrar of the appropriate College. • Ask the person for their written permission to include their name in the report.	• Make light of the situation. • Assume that the crisis has passed. • Try to explain the behaviour as having been misinterpreted. • Guarantee quick fixes or other promises that cannot be kept. • Display a strong emotional reaction of shock, disgust, or embarrassment.

Consequences for Failing to Report

Any person who fails to file a required report as outlined above, is guilty of an offence and if convicted is liable for a fine up to $25,000 for a first offence[17]. Additionally, if you, as a Member of the CRTO, fail to file a report as required, you may be subject to professional misconduct proceedings[18].

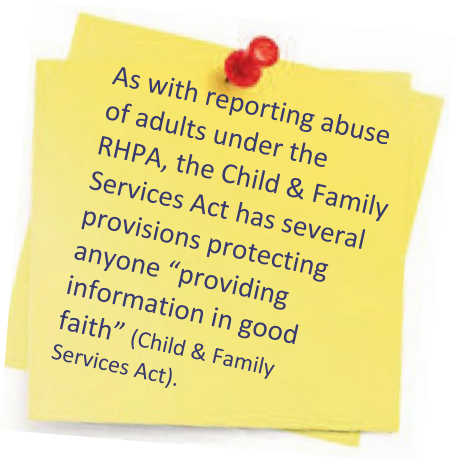
[17] Code section 93(4)
[18] O.Reg 753/93 Professional Misconduct Section 24, Code section 51(2)

The *RHPA* expressly states that anyone making a report in good faith and on the belief that there are reasonable grounds is protected from retaliation (*HPPC*, Ss.92.1).

Responsibilities Related to the *Child and Family Services Act*

The *Child and Family Services Act* (CFSA) exists to protect and promote the best interests and well-being of children under 16 years of age. The legislation articulates the duty to report a child in need of protection and outlines the reasons a child might be in need of protection[19], which includes but is not limited to a child that:

- has suffered, or is likely to suffer, physical harm;
- is neglected or is subject to a pattern of neglect;
- has been, or is likely to be, sexually molested or exploited;
- requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or other person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment; and/or
- has been abandoned.



The CFSA outlines that health care professionals have a particular responsibility to report suspicions of abuse of children. The Act makes it an offence for a health care professional to not report their suspicion when it is based on "information obtained in the course of his or her professional or official duties"[20]. The Act also articulates the ongoing duty to report subsequent suspicions of abuse, even if the health care professional has already made previous reports on the same child.

[19] Ss 72.1
[20] S.72.0(5)

Scenario

A child is brought into emergency with a severe asthma exacerbation. Upon chest x - ray it is noted that he has lateral and posterior rib fractures that are highly specific for abuse. The health care team discusses their suspicions of abuse and the RT assumes that the physician or one of the nurses will file a report with CAS.

What do you do?

A person who has reasonable grounds to suspect a child is or may be in need of protection must report immediately and directly to the CAS and **cannot rely on anyone else to make the report**. There is also an ongoing duty to report any additional suspicions, even if previous incidents have already been brought to the attention of the CAS.

RTs Experiencing Abuse

Occasionally, an RT may be subject to abuse by a patient/client, the patient's/client's family members, and/or other individuals in their workplace environments. RTs should take the appropriate steps to protect themselves when their personal safety is threatened and report all incidents of abuse to the appropriate person (i.e., manager/supervisor). If there is a significant threat or risk of injury to a Member, it may be necessary to leave the area and reassess the situation. The decision to withdraw or withhold care or services from a patient/client is not common and only used as a last resort. Please refer to your employer's policy. For information on documenting such incidents, see the CRTO Documentation PPG- Withdrawal of Care/Services Due to Abuse or Violence.

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:

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