

DECEMBER 2018

# Community Respiratory Therapy Practice

## 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.

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

**I**t is important to note that employers may have policies related to Respiratory Therapists authority to perform certain procedures; including controlled 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.

**NOTE:** For the purposes of this practice guideline the term client is used to refer to both a patient and/or client.

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## Introduction

As our population ages, community care becomes increasingly important. The purpose of this Professional Practice Guideline is to support **Registered Respiratory Therapists (RRTs)** who work in a community setting, which may include traditional locations such as clients' homes and physicians' offices, as well as non-traditional sites, such as schools and assisted living facilities. Community practice enables RRTs to apply their specialized body of Respiratory Therapy knowledge and skills to the treatment and management of a diverse patient/client population in a range of unique settings. Community practice encompasses the provision of RT services outside of a hospital setting, including, but not limited to:

- outpatient education, chronic disease prevention, rehabilitation and management,
- clinic-based diagnostic testing,
- direct client care in a home or primary care setting (e.g., Family Health Teams or FHTs), or
- pharmaceutical and/or medical equipment education and sales.

RRTs who practice in the community often face different opportunities and challenges than their colleagues working in hospitals. A key distinction is the uniquely autonomous nature of community practice, which requires RRTs working in that setting to be self-directed and possess a high degree of professional competency. This is because RRTs in the community are regularly required to independently make important care decisions and act in accordance with their own personal knowledge and judgement. RRTs working in the community are also often responsible for the safe keeping of clients' personal health information and setting their own daily schedules and therefore, must be disciplined and have well established organizational skills.

The fact that community care is often provided in the patient's/client's place of residence and/or over a prolonged period of time alters the nature of the professional relationship. Clients and their families may play a more integral role in directing care in the community, which requires the RRT to employ a holistic approach that allows for the tailoring of services to meet the clients and their families' unique personal situations, needs and goals. Lengthy interaction between the RRT and the patient/family member can also make it more challenging to maintain appropriate professional boundaries and avoid such things as interpersonal issues and conflicts of interest.

The information contained in this Professional Practice Guideline (PPG) covers a wide range of topics that relate specifically, although not exclusively, to community RT practice. It is important to note that all RRTs, regardless of where they work, are required to maintain and uphold the **Standards of Practice** of the profession established by the CRTO, as well as all relevant legislation and regulations.

**NOTE:** For the purposes of this practice guideline the term client is used to refer to both a patient and/or client.

## Business Practices

Providing care in the community, as opposed to a hospital, brings the business side of health care much closer to RRT practice. The [CRTO Standards of Practice](#) states that “RRTs must only engage in business practices that are transparent, ethical, and not misleading to the public.” Privacy and confidentiality, security of **Personal Health Information (PHI)** and ethical, evidenced-informed care are essential in all health care settings. However, providing RT services in the community may necessitate that other concerns such things as billing, sales taxes and advertising also be taken into consideration. This section on business practices endeavours to clarify how these and other aspects need to be managed in community RT practice.

## Privacy and Confidentiality

Federal and provincial legislation protect clients’ rights to privacy and confidentiality of their PHI. Therefore, RRTs have a legal obligation, as well as a professional and ethical obligation, to ensure that their clients’ PHI remains secure and confidential. The following two agencies listed below have been tasked with enforcing this legislation:

### 1. Office of the Privacy Commissioner of Canada

The mission of the Office of the Privacy Commissioner of Canada (OPC) is to protect and promote privacy rights of individuals by enforcing compliance with the [Personal Information Protection and Electronic Documents Act \(PIPEDA\)](#). This legislation aims to protect the private sector data of Canadians and gives an individual the right to lodge a complaint with the Privacy Commissioner of Canada about any alleged mishandling of their personal information. More information on how this piece of legislation applies to RT practice in the community can be found in the section [Personal Information Protection and Electronic Documents Act \(PIPEDA\)](#) of this document.

### 2. Information and Privacy Commissioner of Ontario

The Information and Privacy Commissioner of Ontario provides oversight of Ontario’s access and privacy laws, which establish the rules for how Ontario’s public institutions and health care providers may collect, use, and disclose personal information. The [Personal Health Information Protection Act \(PHIPA\)](#) is enforced by the Information and Privacy Commissioner of Ontario and applies to almost all RRTs, regardless of where they practice.

## Personal Health Information (PHI)

Subject to certain exceptions set out in *PHIPA*, PHI refers to information about an individual in oral or recorded form that relates to the:

- physical or mental health of an individual
- provision of health care to the individual
- individual's health card number
- identification of the individual's substitute decision maker (if applicable)

## Circle of Care

The term “circle of care” is not a defined term in *PHIPA*. However, the Information and Privacy Commissioner of Ontario states that 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*”<sup>1</sup>. The circle of care includes the health care providers who require specific medical information in order to provide care to a particular patient. In most situations, these health care providers may rely on the **implied consent** of a client to share medical information within the circle of care.

Consent by a client to share information with providers in the circle of care is generally implied. Therefore, a client who accepts a referral to another health care provider implies consent for sharing relevant information.

If a client cannot provide consent, then a **Substitute Decision-Maker (SDM)** becomes part of the circle of care, and can provide consent on the client's behalf to allow PHI to be shared within the circle of care.

**Express consent** is required to share information with non-custodians outside the circle of care (e.g., family members who are not a guardian or SDM, police, insurance company, etc.)

More information on the Circle of Care can be obtained from the document published by the Information and Privacy Commissioner of Ontario entitled [Circle of Care: Sharing Personal Health Information for Health-Care Purposes](#).

### Example...

A physician orders home oxygen for a client and the client agrees with the physician's plan of care. This means that the client has given implied consent for the RRT(s) who will be providing their oxygen to be part of the circle of care. The RRT(s) is, therefore, permitted to access the client's PHI and share that information within the circle of care.

<sup>1</sup> Information and Privacy Commissioner of Ontario. (August 2015). Circle of Care Sharing Personal Health Information for Health-Care Purposes. Retrieved from <https://www.ipc.on.ca/wp-content/uploads/Resources/circle-of-care.pdf>

## Sharing PHI Outside the Circle of Care

As outlined previously, RRTs have a legal and professional obligation to maintain the confidentiality of client's PHI. There are circumstances, however, where health care professionals are either required or permitted to report particular events or clinical conditions to the appropriate government or regulatory agency. In Canada, provincial, territorial and federal statutory requirements mandate that health care providers report to the appropriate agencies when certain conditions apply. RRTs who work in the community, particularly those who have established an independent practice, need to be aware of the relevant mandatory reporting requirements. Some examples of circumstance where information either must or can be shared outside the circle of care include:

### *A Child in Need of Protection*

The Ontario [Child and Family Services Act](#) stipulates that it is the law to report suspected child abuse or neglect. Therefore, if an RRT has **reasonable grounds** to suspect that a child is or may be in need of protection, they must report it to their local Children's Aid Society (CAS). It is not necessary to be certain a child is or may be in need of protection to make a report to a CAS, and an RRT must not rely on anyone else to report on their behalf. Any health care professional who fails to report a suspicion is liable on conviction to a fine of up to \$5,000, if they obtained the information in the course of their professional duties.

### *Concerns about a Client's Fitness to Operate a Motor Vehicle*

In Ontario, certain health care practitioners are required by law to report clients who may be medically unfit to drive. Under the Ontario [Highway Traffic Act](#) (s. 302), mandatory reporting requirements for high risk medical conditions, vision conditions and functional impairments that make it dangerous for a person to drive apply only to physicians, optometrists and nurse practitioners (NP). If, as part of their professional interactions, an RT becomes concerned about a client's fitness to operate a motor vehicle they are encouraged to share their suspicions with the client's primary care physician/nurse practitioner.



## *Clients with Certain Communicable Diseases*

Under the authority of the [Health Protection and Promotion Act \(HPPA\)](#), (s.25), a specified list of diseases must be reported to the local Public Health Unit by certain health care professionals. The following are examples of communicable diseases that must be reported to the local Medical Officer of Health:

- Chickenpox (Varicella)
- Measles
- Meningitis
- Severe Acute Respiratory Syndrome (SARS)

RRTs are not one of the practitioners listed in *HPPA* who have a legal duty to report disease. However, because such reports are in the public interest, RTs are encouraged to communicate any concerns of a communicable disease to the client's primary care physician/nurse practitioner. The complete list of reportable communicable diseases is available from each local Public Health Unit.

In addition, *HPPA* (s.38) now requires all health care professionals (including RRTs) who provide immunizations to report [Adverse Event Following Immunization Report \(AEFIs\)](#) to the medical officer of health of the health unit where the immunization took place.

## *Disclosures Related to Risks*

*PHIPA* permits **Health Information Custodians (HICs)** to disclose confidential personal health information to relevant authorities "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"<sup>2</sup>.

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<sup>2</sup> PHIPA [s. 40(1)].

## Security of Personal Health Information

Unique challenges to the privacy and confidentiality of PHI can arise in a community care setting, particularly when PHI is being transported to and communicated in an unsecure location. The risk of information being lost or stolen is greater when it is being taken out of a more secure location (e.g., a home care company office) to an outpatient clinic or client's home. In addition, sharing PHI in a less secure location runs a greater risk of disclosing sensitive information to individuals who are outside the circle of care (e.g., relatives, neighbours).

## Information Privacy and Access Legislation

The specific legislation that applies to RRTs depends, to some degree, on the practice setting and the nature of the RT services being provided. Relevant legislation to community RT practice may include the:

- [\*Freedom of Information and Protection of Privacy Act\*](#)
- [\*Personal Information Protection Act\*](#)
- [\*Personal Information Protection and Electronic Documents Act\*](#)

## *Freedom of Information and Protection of Privacy Act (FIPPA)*

*FIPPA* applies to most provincial agencies, Local Health Integration Networks (LHIN) and public hospitals. It gives individuals in Ontario access to government-health information, including general records and records containing their own personal information. If an individual feels their privacy has been compromised by a public institution governed by the *Act*, they may lodge a complaint to the Information and Privacy Commissioner of Ontario (IPC) who may investigate the complaint.

## *Personal Health Information Protection Act (PHIPA)*

*PHIPA* establishes the rules in relation to the collection, use and disclosure of PHI. These rules apply to all HICs and to individuals and organizations that receive PHI on behalf of the HIC<sup>3</sup> (Agents of HICs) . The *Act* defines HIC and Agents of HICs as follows:

### Health Information Custodian

A HIC is the person or organization who has custody of PHI on behalf of clients, such as:

- Health Care Practitioners who operate a health care practice
  - o Includes anyone who provides health care services for payment, regardless of whether or not the services are publicly funded. *PHIPA* defines “health care” as any assessment, care, service or procedure that is done for a health-related purpose<sup>4</sup>.

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<sup>3</sup> Information and Privacy Commissioner of Ontario. (December 2004). A Guide to the Personal Health Information Protection Act. Retrieved from <https://www.ipc.on.ca/wp-content/uploads/Resources/hguide-e.pdf>

<sup>4</sup> *Personal Information Protection Act*. (2004).

- Community Health Facility (as defined by the [Oversight of Health Facilities and Devices Act](#))<sup>5</sup>
  - o Includes diagnostic facilities (e.g., sleep studies, pulmonary function testing) and surgical/therapeutic facilities (e.g., anaesthetic services for out-of-hospital surgical procedures).
- Service Providers who provide a community service (as defined by the [Home Care and Community Services Act](#))
  - o “Respiratory Therapy Services” is listed as a professional service in the [Provision of Community Services Regulation](#) (s. 3.1(4) - O. Reg. 386/99) which was created under the *Home Care and Community Services Act*.

HICs are responsible for implementing and following information practices that comply with *PHIPA*.

### Example...

If an RRT is working independently (e.g., is a sole practitioner; has established their own company), they are considered to be the HIC. This means that the RRT is responsible for setting the privacy standards for handling and securing PHI in their organization and for making sure that any agents of the HIC working for them understand what is expected of them.

### PLEASE NOTE:

As of March 1, 2019, RRTs and all other regulated health professionals who are Health Information Custodians (HICs) will be required to provide an annual report to the Information and Privacy Commissioner (IPC). The annual report must identify the number of times, in the preceding calendar year, personal health information in the HIC’s custody or control was stolen, lost, used without authority, and/or disclosed without authority (examples include: loss of paper client records, misdirected fax or emails, a health professional who does not provide care to a client reading the client’s record).

<sup>5</sup> [Oversight of Health Facilities and Devices Act](#) has not been proclaimed, however is intended to replace the *Independent Health Facilities Act*.

## Agents of Health Information Custodians (HIC)

An agent of a HIC includes anyone who is authorized by the HIC to provide services on behalf of the custodian with respect to PHI. Examples include:

- Employees of the health information custodian
- Volunteers or students who have any access to personal health information

All client medical records must be stored securely to ensure the integrity and confidentiality of their PHI. Paper records must be stored in:

- Restricted access areas; and/or
- Locked filing cabinets.

### Example...

If an RRT is working as an employee for an organization (e.g., home care company, FHT), they are considered to be an “agent of the HIC”. This means that the RRT must comply with the *PHIPA* policies put in place by the HIC (their employer).

## Retention of Electronic Medical Records

**Electronic Medical Records (EMR)** must be backed-up on a routine basis and back-up copies stored in a physically secure environment separate from where the original data is normally stored. All PHI contained on an EMR, external storage media, or a mobile device must be strongly encrypted.

## Transporting Personal Health Information (PHI)

When PHI is being moved from one location to another (e.g., from an office to a client’s home), all reasonable steps must be taken to ensure they are protected from theft, loss and unauthorized access

Under *PHIPA*, if a HIC is in the custody of a client’s PHI that is lost, stolen or used or disclosed without proper authority, the HIC must notify the individual at the first reasonable opportunity<sup>6</sup>.

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<sup>6</sup> PHIPA [s.12(2)]

## Transfer of PHI

A HIC may transfer a client's PHI records to the custodian's successor, provided the HIC makes reasonable efforts to give notice to the patient(s) before transferring the records or, if that is not reasonably possible, as soon as possible after transferring the records.

## Disposal of PHI

RRTs who are a HIC have a legal requirement to retain client's PHI for the following time periods:

- Adult clients: records must be kept for 10 years from the date of the last entry in the record.
- Clients who are children: records must be kept until 10 years after the day on which the client reached or would have reached the age of 18 years.

If an RRT ceases to practise or act in the capacity of a HIC, the PHI must be retained for the periods outlined above unless complete custody and control of the records are transferred to the custodian's successor.

When the obligation to retain medical records outlined above comes to an end, the PHI may be destroyed, provided that this occurs in a manner that is in keeping with the obligation of maintaining confidentiality and requirements of *PHIPA*.

### Disposal of Electronic Medical Records (EMRs)

There are basically two ways to securely destroy digital information:

1. physically destroy the storage media;
2. overwrite the information stored on the media

The best method to securely destroy personal information will vary depending on the type of media (e.g., hard drives, USB flash drives). Note that some devices, such as printers, fax machines, and smart phones, may contain multiple types of storage media, with each type requiring a different information destruction method<sup>7</sup>.

## *Personal Information Protection and Electronic Documents Act (PIPEDA)*

The Office of the Privacy Commissioner of Canada oversees compliance with the Personal Information Protection and Electronic Documents Act (PIPEDA), which is federal legislation relating to data privacy in the private sector. Therefore, PIPEDA generally only applies to RRTs working in private practice.

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<sup>7</sup> Information and Privacy Commissioner of Ontario. *Disposing of Your Electronic Media*

# Privacy Breaches


A privacy breach involves the improper or unauthorized collection, use, disclosure, retention or disposal of personal information. A privacy breach may occur within an institution or off-site and may be the result of inadvertent errors or malicious actions by employees, third parties, partners in information-sharing agreements or intruders.

Regardless of the nature of the breach, they must be reported by the HICs to the Information and Privacy Commissioner of Ontario. No actual harm has to have happened to the client as a result of the breach for reporting to be required. More information of reporting privacy breaches can be found in the [Reporting a Privacy Breach to the Commissioner Fact Sheet](#).

RRTs are subject to persecution for breaches of *PHIPA*. An RRT found guilty of committing an offence under *PHIPA* can be liable for a fine of up to \$100,000, while an organization /institution can be liable for a fine of up to \$500,000<sup>8</sup>.

Privacy breaches can occur in a number of different ways.

- unguarded conversations
- lost/misdirected documents (e.g., a client's file being left on public transit, PHI being sent to the wrong patient)
- use or disclosure without authority (i.e., accessed by someone who is outside of the circle of care)
- stolen information (e.g., paper records or laptop being taken from the RT's car; ransomware or other malware attack on a Family Health Team's (FHT) computer system)\*



\* **NOTE** that the HIC does not need to notify the Commissioner if the stolen information was de-identified or properly encrypted.

## PLEASE NOTE:

As of November 1, 2018, organizations subject to PIPEDA will be required to:

- (a) report privacy breaches to the Office of the Privacy Commissioner of Canada and others in certain circumstances;
- (b) notify affected individuals about those breaches;
- (c) keep records of all privacy breaches.

Generally, this requirement only applies to RRTs working in private practice who are Health Information Custodians.

<sup>8</sup> Information and Privacy Commissioner of Ontario. <https://www.ipc.on.ca/health/breach-repoRTing-2/potential-consequences-of-a-breach-under-phipa/>

## Professional Incorporation

The CRTO has processes in place to issue Certificates of Authorization for health profession corporations. RRTs who independently practice Respiratory Therapy are not currently required by the CRTO to do so through a health profession corporation.

More information on Professional Incorporation can be found on the CRTO website in the section entitled [Guide to an Application for a Certificate of Authorization for Health Professional Corporations](#).

## Fees and Billing

Not all services or equipment that a client in the community requires may be covered by OHIP. As a result RRTs, or their employers, may have to deal with fees, billing and payment for care that is covered by the client directly, or a **third party payer** such as the Assistive Devices Program (ADP) or private insurer. RRTs should understand that money often changes individuals' expectations regarding services being provided as they perceive themselves to be consumers<sup>i</sup>. This shift alone can alter the power imbalance between health care provider and client, at least at the time money is changing hands. RRTs have a professional obligation to ensure that their business practices are transparent, ethical and not misleading to the public<sup>ii</sup>.

### *Communicating Fees and Billing to Clients*

RRTs are expected to clearly and accurately inform clients of all required fees for products and services, ensuring that there are no hidden costs, prior to the initiation of care<sup>iii</sup>. Doing so will help avoid conflicts with clients as long as the information is communicated in a thoughtful manner, taking into consideration the broad spectrum of financial circumstances that clients bring. RRTs should be sensitive to the personal situations and ensure they convey that the client's care and well-being are paramount.



### **Avoiding fee conflicts...**

The CRTO recommends that RRTs consider implementing a checklist or consent form that clients would sign, outlining fee schedules and clearly describing billing procedures including:

- any penalties for missed or cancelled appointments,
- late payment of fees,
- the facility's policy regarding the use of collection agencies to collect unpaid fees, and
- third party fee payments (e.g., private insurers).

In addition to helping to guide you, or your employees' discussions with clients, if there is a dispute later you will both have a record of the information communicated. RRTs are also expected to establish processes for detailing fee or billing discrepancies and errors in a timely manner. Making these processes transparent will further reduce conflicts.

### *Overcharging or Excessive Fees*

Charging a fee that is excessive for the services or equipment provided is a form of dishonesty. While there may not always be a fixed amount that an RRT must charge, or a maximum fee that can be charged, at some point a high fee becomes excessive. Similarly, requiring a client to purchase upgraded equipment or additional services without their prior knowledge or ability to opt out is unethical and unprofessional.

### *Offering Discounts*

Actions that may be perceived to lessen the value of the professional, the profession or health care as a whole is not allowed. For example, the use of Groupon™ or other bulk-purchase websites is strictly prohibited<sup>9</sup>. It is permissible for an RRT to offer discounts for their services as long as certain provisions are in place; discount advertisements must not state anything false or misleading, and the RRT must not try to recoup the discounted fee by raising fees for other services.

Offering a reduction in cost for prompt payment is not allowed as it gives preferential treatment to those who have the financial resources to take advantage of this discount, while essentially penalizing those who don't have the means to. This does not prevent RRTs from being able to implement additional charges for late payments; the terms of late payment charges should be clearly outlined for clients in advance.

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<sup>9</sup> CRTO Standards of Practice – Standard 1 - Business Practices.

## *Payment Options*

Respiratory Therapists should explain all payment options available to their clients. This includes explaining coverage through ADP and inquiring as to whether the client has private insurance coverage, and the limitations of that, if known. RRTs should be cognisant of clients who are financially vulnerable and communicate sensitively regarding billing.

## *Dealing with Third Party Payers*

Many services and equipment required by clients of RTs will be covered by OHIP or, at least in part, by the ADP under the Ministry of Health and Long-Term Care. The balance of fees not paid directly by one of these two entities may be covered by private health insurance or may require payment directly from the client. Respiratory Therapists may not charge a higher fee for insured clients than those who pay directly. To do so would be considered dishonest, inappropriate and unprofessional.

RRTs should become familiar with the insurance requirements of their clients in order to ensure their billing or invoicing practices will result in the claim being processed. Billing to third-party payers must reflect a true account of services/equipment provided and collected by your practice.

# Professional Advertising

Professional advertising relates to any material that is used to promote an RRT's professional practice.

RRTs can use various mediums for advertising their services such as:

- business cards,
- websites, and
- newsletters (electronic or paper-based).

Regardless of the advertising method, there are some common considerations when advertising RT services.

An RRTs professional advertising must not:

- contain false or misleading statements (e.g., stating that your services are "CRTC endorsed");
- It must not contain statements that cannot be verified (e.g., stating that your services are "the best in the region");
- demean another member of your own profession or another profession (e.g., stating that they "...provide superior home care services when compared to all other health care providers");
- advertise products and services that the RT does not have the competence to provide;
- contain a name different than the name that the RT has registered with the CRTC (i.e., the public has to be able to find the RT on the public Register of Members on the CRTC website).

The RHPA grants regulatory Colleges the authority to develop a regulation governing advertising. RTs in Ontario must adhere to all the advertising parameters set out in the [CRTC Advertising Regulation](#). In addition, the performance requirements for RTs regarding advertising and marketing are articulated in the CRTC Standards of Practice ([Standard 1 - Business Practice](#)).

# Business Ethics

## *Solicitation of Clients*

Solicitation involves contacting individuals directly, either face-to-face, over the telephone or other direct means of communication, to encourage them to use an RRT's services. Directly soliciting an individual to become a client is not permitted because it places the RRT's personal interest above the interest of the patient.

The [CRTO Advertising Regulation](#) (s. 5) states that an RRT must not initiate contact with any persons for the purpose of soliciting business.

## *Testimonials*

It is a conflict of interest to contact a client for personal testimonials. The [CRTO Advertising Regulation](#) [s.23(2)(e)] and the [CRTO Standards of Practice](#) states that RRTs must not include testimonials in their advertising. Therefore, RRTs are not allowed to use a testimonial by a patient, former client or by a friend/relative of a client/former client in any promotional material, regardless of the medium.

### **Example...**

If a client is asked for a testimonial, they may be concerned that refusing could negatively affect their relationship with the RT. This can also be true for former clients, who may feel uncomfortable in returning for treatment in the future.

# Professional Practice

## *Regulated Health Professional Act (RHPA)*

The [Regulated Health Professions Act](#) identifies a number of specific activities as controlled acts; designated as such because they carry a higher degree of risk of harm associated with their performance. These controlled acts are subsequently authorized through profession specific legislation, such as the [Respiratory Therapy Act](#).

## Exception in the RHPA

There are a number of exceptions in the RHPA [s.29 (1)] that enable individuals to perform controlled acts that they do not have the legislative authority to perform. The two exceptions that are most relevant to community practice are as follows:

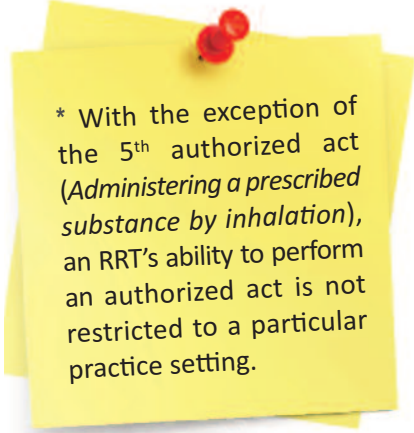
- treating a member of the person's household (e.g., a client's family member administering invasive mechanical ventilation to the client in their home)
- assisting a person with their routine activities of living (e.g., a Personal Support Worker (PSW) suctioning a client in an outpatient tracheostomy clinic)

More information on these exceptions can be found in the [CRTO's Interpretation of Authorized Acts Professional Practice Guideline](#).

## Controlled Acts Authorized to Respiratory Therapists

Subject to any **Terms, Conditions and Limitations** on an RRT's certificate of registration, the controlled acts authorized to Respiratory Therapists are:

- *Performing a prescribed procedure below the dermis.*
- *Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx.*
- *Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx.*
- *Administering a substance by injection or inhalation.*
- *Administering a prescribed substance by inhalation\*.*



\* With the exception of the 5<sup>th</sup> authorized act (*Administering a prescribed substance by inhalation*), an RRT's ability to perform an authorized act is not restricted to a particular practice setting.

Other health care professionals are also permitted to perform these controlled acts; either because they are also legislatively authorized or they have had the acts delegated to them. In addition, other tasks performed by RTs are part of the **public domain**, and can be performed by anyone who is competent to do so. When performing a procedure, it is important to determine whether the task is a controlled act or not.

### Example...

The “administering a substance” portion of the 4<sup>th</sup> Authorized Act (*Administering a substance by injection or inhalation*) enables RRTs to apply non-invasive ventilation (i.e., CPAP, BiPAP). Simply placing a CPAP mask or other interface on a client does not fall under this controlled act

### Example...

RRTs are authorized by the Prescribed Procedures regulation to perform an arterial puncture. This procedure can be performed by an RT in any employment setting (e.g., hospital, an outpatient clinic, a client’s home) provided it is permitted by their employer.

## Administering a Prescribed Substance (5<sup>th</sup> Authorized Act)

The 5<sup>th</sup> authorized act (“*administering a prescribed substance*”) enables RRTs to independently administer oxygen. “Prescribed” in this context means prescribed in regulation<sup>10</sup> and “independently” means the oxygen therapy can be provided without the requirement of an order.

This means that, in certain practice settings, RRTs can administer initiate, titrate or discontinue oxygen based solely on their own professional judgement. However, it is important to understand that there are other pieces of legislation and policies limiting where RTs can independently administer.

The [Public Hospitals Act](#)<sup>11</sup> requires an order for every treatment or diagnostic procedure and the [Independent Health Facilities Act](#)<sup>12</sup> requires an order for all examinations, tests, consultations, and treatments. Therefore, RRTs are only permitted to independently administer oxygen in practice setting where these two pieces of legislation do not apply (e.g., in a client’s home).

## Assistive Devices Program (ADP)

The Assistive Devices Program (ADP) authorizes RRTs who meet specific criteria to complete the Application for Funding Home Oxygen in place of the prescriber. Therefore, when a physician or a nurse practitioner prescribes home oxygen therapy, an eligible RRT may complete the application – provided they are not employed (full-time, part-time or casual) for a home care company.

More information can be found of the CRTO website in the section entitled [ADP Home Oxygen Application](#).

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<sup>10</sup> General Regulation (O. Reg. 596/94 – PART VII) - Prescribed Procedures

<sup>11</sup> Public Hospital Act, O. Reg. 965 s. 24

<sup>12</sup> Independent Health Facilities Act, O. reg 57/92 s. 10

## Local Health Integration Network (LHIN) Home and Community Care Services

Fourteen (14) Local Health Integration Networks across the province provide access to home and community care services for Ontario residents and co-ordinate admission to long-term care facilities. These LHINs coordinate access to a wide range of contracted services in the community, including Respiratory Therapy.

The [Provision of Community Services Regulation](#) (s.3.1(4) - O. Reg. 386/99), which was created under the [Home Care and Community Services Act](#) lists Respiratory Therapists as a service provider. The [Respiratory Therapy Services Schedule](#) is utilized by the LHINs to determine the range of funded services that an RT can provide in the community.

## Terms, Conditions and Limitations on an RTs Certificate of Registration

Terms, conditions and limitations (TCLs) are restrictions placed on the certificate of registration of certain classes of registration and on certain Members for specific reasons. All Graduate Respiratory Therapists (GRTs), Practical (Limited) Respiratory Therapists (PRTs), as well as some RRTs have TCLs. RTs who have TCLs on their certificate of registration are permitted to practice, provided their workplace is able to accommodate their practice restrictions.

### Example...

GRTs are only permitted to perform a controlled act that is authorized to the profession if it is performed under general supervision. This supervision can be provided by any regulated health care professional (e.g., RRT, RN, MD) who is authorized to perform the controlled act and is competent to do so. General supervision requires that the supervising health care professional be available to be “personally present” by the RTs side within ten minutes, if necessary.

### How TCLs are Lifted

TCLs may be removed from an RT’s certificate of registration in a variety of ways. GRTs generally have their TCLs lifted after they successfully complete the Canadian Board of Respiratory Care (CBRC). Other PRTs or RRTs who have TCLs must first submit a request to, and receiving approval from, the CRTO Registration Committee.

More information can be found on the CRTO website in the section entitled [Terms, Conditions and Limitations](#).

## Professional Relationships

In accordance with the Standards of Practice, RTs must act with honesty, integrity, and respect appropriate professional boundaries with patients/clients, healthcare team members, students, and others. An important part of being a regulated healthcare professional is recognizing how a power imbalance can impact both therapeutic and professional relationships, and taking steps to ensure that you are acting with integrity in all interactions, including abstaining from entering into personal relationships where professional boundaries could be compromised.

## Providing Care in a Community Setting

Care in the community, particularly home-based care, is fundamentally different than the episodic, targeted interventions of the acute care system. Service provided near or in a client's home requires a uniquely holistic, self-directed and patient-centered approach to care delivery. Home-based care presents opportunities to better integrate the plan of care into the client's day-to-day environment, but also present some challenges as well, such as:

- Lack of control over elements of the home environment (e.g., location, cleanliness, available of amenities)
- Interactions with other household members (e.g., dysfunctional interpersonal relationships within families)
- Threat to the RTs safety (e.g., clients/family member engaging in illegal activities)
- Maintaining professional boundaries (e.g., avoiding conflicts of interest)



# Conflict of Interest

The primary goal of health care is to optimize the health of clients. This means that the interest of the client must always come first and not a financial interest. A conflict of interest arises when a secondary goal (e.g., personal gain for the health care provider) interferes or is perceived to interfere with the primary goal. The CRTO's [Conflict of Interest Professional Practice Guideline](#) states that "a conflict of interest exists when an RRT is in a position where his/her duty to their client could be compromised, or could be perceived to be compromised, by a personal relationship or benefit". The nature of community practice (i.e., long standing RT and patient/family interactions; financial compensation for services provided) has the potential to increase the risk of a conflict of interest situation developing. Any actual, potential or perceived conflict of interest must be properly identified, avoided and managed so as not to compromise the client's best interests.

## Identifying a Conflict of Interest

The first step is to recognize that a conflict of interest situation may exist. The [Conflict of Interest Regulation](#) (O. Reg. 596/94) outlines the situations in which an RRT might find themselves in an actual, potential or perceived conflict of interest [s. 3 (1)]. The likelihood of a conflict of interest increases when:

- The magnitude of the benefit is substantial
- The benefit is personal
- It involves a client (or their family) where there is an ongoing professional relationship (e.g., a current home care client offers their RT a piece of antique china).

### Example...

An RRT working for a home care company has been providing care for a client in their home for a number of years. In gratitude for the services the RRT has provided, the client's family offers the RT a gift card.

Even if the RRT believes that the gift will not impact on the care they will continue to provide to the client - the RT must still politely decline the offer. This is because accepting the gift could potentially be perceived by the client's family or others as altering the RRT to client relationship.

In situations where a conflict of interest situation exists, the RRT must declare the nature of the relationship/benefit to the client in advance of services being provided. This should occur regardless of whether the conflict of interest is actual, potential or perceived.

### **Example...**

An RRT who works for a hospital that is part of a hospital-home care company business relationship is making arrangements for an inpatient to be discharged with home oxygen. In addition to the home care company that is associated with the hospital, the RRT should – if possible – provide the client with other appropriate service providers. Where applicable, the RRT should advise the client that their selection of a supplier or a product or service will not adversely affect the assessment, care or treatment that they receive. This enables the client to exercise informed choice over the services provided to them. This includes allowing them to select a service provider, as well as the type of equipment/treatment received.

## Working with Other Members of the Health Care Team

RRTs practicing in the community typically work with a diverse group of health care providers; some of whom are Regulated Health Care Professionals (RHCPs) (e.g., RNs, MDs, RSLPs), as well as some who are Non-Regulated Health Care Providers (NRHCPs) (e.g., PSWs, Customer Service Technicians).

NRHCPs can include an array of paid care providers and unpaid family members. One of the key considerations for RTs when working with NRHCPs in the community is to determine which services the NRHCP can provide to the client and which services are best provided by the RRT. As outlined in an earlier portion of this document entitled [Exceptions in the RHPA](#), there is a legislative framework that enables care to be provided by NRHCP in the community under certain circumstances. As a regulated health care professional, the RT member of the health care team is expected to ensure that their clients receive optimal Respiratory Therapy services. If the RRT has any concerns regarding the care their client is receiving from any member of the health care team, the RT is expected to raise those concerns with the client's primary care physician/nurse practitioner.

In addition to assisting other members of the health care, the RT practicing in the community is expected to know when it is appropriate to seek assistance from others.

More information on NRHCPs can be found on the CRTO website in the section entitled [Working With Non-Regulated Health Care Providers](#).

# Education and Delegation

Due to the fact that community-based RRTs interact with such a wide variety of care providers, it is essential to understand the difference between delegation and education, as well as which is required in certain circumstances. The [CRTO Delegation of Controlled Acts PPG](#) and the [CRTO Respiratory Therapists Providing Education PPG](#) provides detailed information on these two processes, which is briefly summarized in the table below:

	Education	Delegation
<b>What is it:</b>	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.
<b>What it applies to:</b>	Applicable to any procedure/activity (may or may not be a controlled act).	Controlled act procedures only.
<b>Who may do it:</b>	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.

**Note:** Above chart is from the [Respiratory Therapists Providing Education PPG](#) (p. 7).

## When Delegation is Required

When it is necessary for the transfer of legal authority to perform a controlled act to a person not authorized to perform that controlled act (e.g., an RRT transferring the authority to administer oxygen to a PSW in a Long-Term Care facility).

## When Delegation is Not Required

- When a RHCP already has the legislative authority to perform the controlled act
- When the procedure is not a controlled act (i.e., part of the public domain)
- When the procedure and situation meets the criteria of one of the exception in the *RHPA*<sup>13</sup>

<sup>13</sup> RHPA. [s.29(3)]

# Communication and Collaboration

Despite the fact they frequently work alone, highly developed communication and interpersonal skills are also essential for an RRT in a community practice setting. Community RRT's are required to explain diagnosis/treatment plans and obtain informed consent from patient, as well as give instructions to anxious clients and/or their family members. In addition, community-based RTs need to maintain an open line of communication with other health care professionals, many of whom are not located at the site where care is being delivered.

## Communication and Collaboration with Clients and their Families

Clients and their family members come in with their vast range of different personalities, cultural backgrounds, and current emotional states (e.g., stress, fear of loss of control). Research evidence indicates that there are strong positive relationships between a health care professional's communication skills and a client's capacity to follow through with recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors<sup>14</sup>. Therefore, an RRT's ability to explain, listen and empathize can have a profound effect on health outcomes as well as client satisfaction and experience of care.

## Communication and Collaboration with Other Members of the Health Care Team

Team communication and collaboration is essential in all health care settings, and can be particularly challenging in community practice where the team members have few opportunities to interact. Often a multidisciplinary approach takes over, in which each team member only feels responsible for the activities related to their own discipline and formulates separate goals for the patient. However, what is needed is an interdisciplinary approach where there is a collaborative effort towards a common goal from all disciplines involved in the care plan. Effective communication among staff encourages effective teamwork and promotes continuity and clarity within the client care team. At its best, good communication encourages collaboration, fosters teamwork, and helps prevent errors.

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<sup>14</sup> <https://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/>

When health care professionals are not communicating effectively, client safety is at risk for several reasons:

- lack of critical information,
- misinterpretation of information,
- unclear orders/plans of care, or
- overlooked changes in status.

## Electronic Communication

Communication accomplished with electronic devices such as computers, tablets and cell phones includes:

- direct verbal communication by phone,
- text-messages or texting,
- email,
- videoconferencing,
- telemedicine,
- online forums,
- client portals, or
- social media platforms (e.g., Facebook™, WhatsApp™).

Despite the convenience of such communication mediums, the use of electronic communications to transmit sensitive information can increase the risk of such information being disclosed to third parties. The [eCommunication Checklist](#) produced by the Canadian Medical Protective Association provides some essential elements to be considered when using electronic communication to convey sensitive PHI.

### eCommunication checklist<sup>15</sup>

- Is the communication within the circle of care?
- Is explicit (written) consent of the client required?
- Is the information secure (encrypted)?
- Is your device password-protected?
- What are the relevant regulatory standards?
- Is only essential information being shared?
- Is person-to-person communication more appropriate?

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<sup>15</sup> Canadian Medical Protective Association. Retrieved from [https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/communication/Privacy\\_and\\_Confidentiality/eCommunication-e.html](https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/communication/Privacy_and_Confidentiality/eCommunication-e.html)

## Obtaining Client Consent to Communicate Electronically

Prior to engaging electronic communication mediums clients should agree to:

- The method of communication
- The type of information that will be sent
- How the information contained in the communication will be retained/deleted
- The risks of using electronic methods of communication

The discussion and client's agreement should be documented in the medical record. Canadian Medical Protective Association (CMPA) has produced a consent template that could be modified and adapted to RT practice. To view the CMPA's template [Consent to use electronic communications \(PDF\)](#). In addition, the Information and Privacy Commissioner of Ontario has published a [Fact Sheet on Communicating Personal Health Information by Email](#) that addresses the risk of email communication and how those risks might be mitigated.

### Encryption

The use of appropriate encryption software to protect electronic messages is a reasonable safeguard under the circumstances. Various enterprise solutions (e.g., client portals) can provide encryption, and an increasing number of encryption applications are available for use on personal devices such as smartphones. RRTs considering using unsecured or unencrypted email or text messaging should do so only for information that does not include identifiable personal health information (e.g., scheduling, reminders).

## Professional Boundaries

In keeping with the Standards of Practice, “Respiratory Therapists must act with honesty, integrity, and respect appropriate **professional boundaries** with **clients, health care team members, students, and others.**” While most RTs will reflect on professional boundaries in relatively limited terms, such as romantic or financial relationships, “professional boundaries” covers every aspect of communication and interaction between RRTs and everyone with whom they come into contact in their roles. Perhaps it is because RTs don’t consider professional boundaries broadly enough that this issue results in the vast majority of investigations conducted by the CRTO; indeed, over 80% of concerns reported to the CRTO are related to professionalism.

“Professionalism” or professional conduct is a term that is often used to describe the behaviours that are expected of individuals who hold a certain role in society. A “professional” is typically someone who has obtained skills that are recognized as requiring specific, intensive training and who applies those skills in a position that impacts others (e.g., engineer, lawyer, RRT, PT, MD, etc.). Professionals are often held to moral, ethical and legal standards because of that potential impact.

In some circumstances, there is an inherent power imbalance between the Respiratory Therapist and the person with whom they are interacting. For example, treating a client, speaking with the SDM or family member of the client, or dealing with a non-regulated health care professional or a Student Respiratory Therapist. In all of these cases, the Respiratory Therapist has status and influence that makes overstepping their professional boundaries especially problematic.

More information can be found regarding Professional Boundaries in the [CRTO Respiratory Therapists Providing Education PPG](#) and the [Abuse Awareness and Prevention PPG](#).



## Medical Assistance in Dying (MAID)

In 2016, the federal government passed legislation to amend Canada's *Criminal Code* and established a framework for Medical Assistance in Dying (MAID) for individuals who meet pre-defined eligibility criteria. RTs in community practice may be required to provide information to clients seeking information about MAID or to assist a physician or NP in carrying out a request for a medically assisted death. Therefore, it is important that a community-based RT be knowledgeable about the following:

- How to handle inquiries about MAID (i.e., criteria for MAID, who the RRT can discuss MAID with), and
- The RRT's role in MAID (i.e., parameters around assisting MAID, acting as an independent witness, conscientious objection)

The above information, as well as additional resources can be found on the CRTO website in the section on the [Medical Assistance in Dying](#).

## Ending Professional Relationships

In most circumstances, RRTs in community practice are obligated to maintain a professional relationship with a client as long as the client requires services from the RT. However, situations may arise that require the RT to end the professional relationship prior to reaching the normal or expected conclusion of the client's treatment. These situations generally fall into one of two categories where the RRT will no longer be able to provide the services:

1. Logistical Reasons (e.g., the RRT is retiring or leaving to work for another organization); and/or
2. Safety and/or Interpersonal Concerns (e.g., RRTs feel the client's home environment poses a threat to the safety of the RT or others; there exists a significant conflict with the client and/or their family members).

## Ending Professional Relationships due to Logistical Reasons

In this situation, care must be transferred to the most appropriate service provider prior to the RT ending the professional relationship. Most organizations have policies in place to deal with the transfer of care process. The section entitled "[Transfer of Care](#)" below deals with some recommendation from the CRTO.

## Ending Professional Relationships due to Safety and/or Interpersonal Concerns

Except where there is a genuine risk of harm, RTs should only end the professional relationship after reasonable efforts have been made to resolve the situation in the best interest of the patient. These efforts must include:

- Proactively communicating expectations for client conduct to all clients
- Having a discussion with the client regarding the reasons affecting the RT's ability to continue providing care.

All reasonable efforts must be made to resolve the situation in the best interest of the patient, and only consider ending the professional relationship where those efforts have been unsuccessful.

### Example...

Most home care companies have a policy in place to deal with situations where there is unsafe use of oxygen in the home (e.g., oxygen in use while patient/family member is smoking). These processes generally include all of the following steps:

1. Inform the client (preferably in writing) of what will happen if they use oxygen in an unsafe manner (i.e., how many warning they will receive and how those warning will be documented).
2. Notify the client (preferably in writing) of the decision to discontinue their treatment.
3. Document in the client's medical record the reasons for the discontinuation of services, as well as all steps undertaken to resolve the issues prior to discontinuation.
4. Clearly convey to the client that they should seek ongoing care (e.g., speak to their primary care physician; go to their local emergency department).
5. Notify the health care provider(s) who ordered the oxygen that the therapy is no longer being provided to the patient. Also consider informing other members of the client's health care team, as appropriate.

## Transfer of Care

When transferring full or partial responsibility for a client's care to another health care provider, an RRT is expected to communicate with the:

- client to identify the roles and responsibilities of the regulated member and other health care providers involved in the client's ongoing care, and
- accepting health care provider(s) to provide any pertinent clinical information, including treatment plans and recommendations for follow-up care.

## Transfer of Client Files

It is important to obtain appropriate authorization (i.e., consent) from the client before transferring any copies of medical records. The RRT should ensure the original records are retained in the event there is some question at a later time about the care you provided to the patient, or in the event of a complaint to the CRTO or legal action surrounding the care or the termination. In addition, the RT should advise the client of the need to transfer copies of medical records to the new physician. You should also request the necessary consent to make the transfer. Consider any Privacy Commission or CRTO guidelines that might apply to the transfer of client records.

## Professional Responsibilities

Respiratory Therapists must ensure their professional practice complies with all applicable regulatory requirements. In addition to maintaining registration with the CRTO, RTs must take accountability for their professional practice and abide by both their employer and CRTO obligations. As responsible practitioners RTs place patients' needs above their own, act as advocates where appropriate and report information that is relevant to their abilities to provide safe, ethical and competent care.

## Documentation

The [CRTO Documentation PPG](#) and the [CRTO Standards of Practice](#) (Standard 7) outlines the principles and standards of documentation that must be maintained by all RRTs in every practice setting. Documentation styles (e.g., narrative charting, charting by exception) and documentation mediums (i.e., paper-based or computer-based) vary from one organization to the next. RTs may utilize any documentation format that meets both the CRTO's expectation regarding documentation and their employer's requirements.

An essential foundational principle for all RT documentation is that every client contact must be documented. "Client contact" includes (but is not limited to):

- performing an examination, diagnostic procedure, therapeutic intervention,
- providing education to a client and/or their family, caregiver or advocate,
- conferring with other members of the health care team (including the client's family members) regarding the client's plan of care (note that this includes even when the client is not present during the conversation).

## Professional Liability Insurance (PLI)

The *Regulated Health Professions Act*<sup>16</sup> requires all practising regulated health professionals to carry PLI that meets specific criteria. The [CRTO Professional Liability Insurance Policy](#) outlines those requirements, as well as the consequences of an RT not being covered by the requisite amount of PLI.

RTs who are “personally insured” by their employer’s PLI plan in the required amounts and coverage are not obliged to obtain additional liability insurance coverage. “Personally insured” means the employer’s insurance policy covers not just the organization, but the RRT as an individual. The policy does not have to list the RRT by name but must specify that it covers the “employees” of the organization as “added insureds”.

Additional PLI is available for members of the provincial or national professional associations (i.e., the RTSO, CSRT).

More information can be found on the CRTO website regarding the [CRTO Professional Liability Insurance Policy](#).

## Reporting Requirements

There are a number of instances where an RRT is required to report specific information to certain organizations/agencies. Some of these reporting requirements were covered in the section in this document entitled [Sharing PHI Outside of the Circle of Care](#). Some additional agencies that community RTs are required to report to are as follows:

### Reporting to the CRTO

There are several instances in which CRTO Members are required to contact the CRTO, such as reporting offences, professional negligence or malpractice, or information regarding registration and conduct.

More about what information must be reported to the CRTO by a Member can be found in the [Mandatory Reporting by Members Fact Sheet](#).

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<sup>16</sup> RHPA. Health Professions Procedural Code. S. 13(1).

An RT who operates their own business and employs other RRTs has specific reporting requirements to the CRTO. Home care companies and other employers of RRTs are obligated to submit a report to the CRTO if they have reason to believe that an RRT:

- has sexually abused a client,
- is incompetent or incapacitated, or
- has committed an act of professional misconduct.

Employers of RTs are also required to report if they terminate or suspend the employment of an RT or take any other form of disciplinary actions against the RRT.

More information on what must be reported to the CRTO by an employer of RRTs can be found in the [Mandatory Facility/Employer Reports Fact Sheet](#).

## Reporting Sexual Abuse of Clients

When an RT has reasonable grounds, obtained in the course of practising the profession, to believe that another RT or regulated health professional has sexually abused a patient, the RRT must file a report in writing with the Registrar of the College to which the alleged abuser belongs.

More information on reporting sexual abuse of clients can be found in the [CRTO Abuse Awareness and Prevention PPG](#).

## Reporting to Other Agencies

Depending upon the community practice setting, there may be other mandatory reporting requirement to agencies outside of the CRTO that are governed by different legislation (e.g., *Long-Term Care Homes Act*). Listed below are just a few addition reporting obligations.

## Considerations When Establishing an Independent RT Community Practice

Although the majority of RTs who work in the community are employed by home care companies or community care clinics, RTs are able to set up their own independent practice. This requires the RT to establish processes for securing client's health records, set fees for their services, ensure they have the required level of professional liability insurance and that they attain optimal business ethics.

1. [Professional Incorporation](#)
2. [Professional Liability Insurance \(PLI\)](#)
3. [Mandatory Facility/Employer Reports](#)
4. [PHIPA](#) and [PIPEDA](#)
5. Requirements under Other Relevant Legislation

The CRTO recommends any RT who is establishing an independent community practice to consult their own legal advisor.

## Glossary

**Assistive Devices Program (ADP)** - provides consumer centered support and funding to Ontario residents who have long-term physical disabilities and to provide access to personalized assistive devices appropriate for the individual's basic needs<sup>17</sup>.

**Electronic Medical Records (EMR)** – is a computer-based client record specific to a single clinical practice, such as a family health team or group practice<sup>18</sup>. EMRs include devices that contain Personal Health Information (PHI), such as:

- magnetic media (such as hard drives, magnetic tapes)
- electronic drives (such as solid-state drives, USB flash drives, memory cards)
- mobile devices (such as smartphones, tablets)

**Express Consent** - may be in oral or written form. Examples of express consent are having a client complete a signed consent form or having a client verbally consent in the presence of another health care professional.

**Health Information Custodian** – responsible for collecting, using and disclosing personal health information on behalf of clients. A HIC is generally the institution, facility or private practice health practitioner that provides health care to an individual.<sup>19</sup>

**Home Care Company** – is a catch-all term used to describe businesses that provide a variety of services and equipment to clients in the community setting. RTs who work for home care companies may provide trach care, home oxygen, Non-Invasive Positive Pressure Ventilation (NIPPV), etc.

**Implied Consent** – is determined by the action of the patient. Implied consent may be inferred when performing a procedure with minimal risk that the client has previously consented to and acts in a manner that implies their consent.

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<sup>17</sup> MOHLTC. Retrieved from <http://www.health.gov.on.ca/en/pro/programs/adp/>

<sup>18</sup> Canada Health Infoway. Retrieved from <https://www.infoway-inforoute.ca/en/solutions/digital-health-foundation/electronic-medical-records>

<sup>19</sup> *Personal Health Information Protection Act*. (2004). Available from: [http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_04p03\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm)



## Glossary

**Independent Practice** – Respiratory Therapists may be self-employed. The CRTO recommends that RTs consult with a lawyer and/or an accountant before deciding to start their own businesses as there are many legal and practical considerations, in addition to their professional obligations to clients and the CRTO.

**Identifying Information** - information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual.

**Personal Health Information (PHI)** - subject to certain exceptions set out in *PHIPA*, PHI refers to information about an individual in oral or recorded form that relates to:

- The physical or mental health of an individual
- The provision of health care to the individual
- The individual's health card number
- The identification of the individual's substitute decision maker (if applicable)

**Reasonable Grounds** - refers to the information that an average person, using normal and honest judgment, would need in order to decide to report.

**Registered Respiratory Therapists (RRTs)** – has been issued a General Certificate of Registration because they have met all academic requirements and has successfully completed the registration examination or evaluation approved by the CRTO, or met the registration requirements under the *Ontario Labour Mobility Act, 2009*. If a Member holds a General Certificate of Registration, they must use the designation RRT and may use “Registered Respiratory Therapist” or “Respiratory Therapist” as their professional title.

**Standards of Practice** – described the requirements that all RRTs must meet for professional practice. The Standards contain practice parameters which should be considered by all Ontario Respiratory Therapists in the care of their clients and in the practice of the profession.

## Glossary

**Substitute Decision-Maker (SDM)** - means a person who is authorized under s.20 of the *Health Care Consent Act* to give or refuse consent to a treatment on behalf of a person who is incapable with respect to the treatment.

**Terms, Conditions and Limitations** - 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.

**Third Party Payer** – any organization/agency (other than the Ontario Health Insurance Plan (OHIP), or self-payment by the patient) that fully or partial funds the health care services that a client receives (e.g., the MOHLTC's Assistive Devices Program; private insurance companies).

## How this Guide Links to the Professional Misconduct Regulation

### 1. BUSINESS PRACTICES

19. Submitting an account or charge for services that a member knows is false or misleading.
20. Charging a fee that is excessive in relation to the service rendered.
21. Failing to disclose the fee schedule or payment structure prior to delivery of services or failing to provide the patient or patient with sufficient time to refuse the treatment and arrange for alternative services.
22. Failing to itemize an account for fees charged by the member for professional services rendered,
  - i. if requested to do so by the patient or patient or the person or agency who is to pay, in whole or in part, for the services, or
  - ii. if the account includes a commercial laboratory fee.
23. Selling any debt owed to the member for professional services; this does not include the use of credit cards to pay for professional services.

## How this Guide Links to the Advertising Regulation


- (1) In this Part, an advertisement with respect to a member's practice includes an advertisement for gases used for medical purposes, equipment, supplies or services that includes a reference to the member's name.
- (2) An advertisement with respect to a member's practice must not contain,
  - (a) anything that is false or misleading;
  - (b) anything that, because of its nature, cannot be verified;
  - (c) a claim of expertise in any area of practice, or with respect to any procedure or treatment, unless the advertisement discloses the basis of the expertise;
  - (d) an endorsement other than an endorsement by an organization that is known to have expertise relevant to the subject-matter of the endorsement;
  - (e) a testimonial by a patient or patient or former patient or patient or by a friend or relative of a patient or patient or former patient or patient; or
  - (f) anything that promotes or is likely to promote excessive or unnecessary use of services.
- (3) An advertisement must be readily comprehensible to the persons to whom it is directed.
- (4) A member must not permit his or her name to be used in an advertisement that contravenes subsection (2) or (3).
- (5) A member must not advertise by initiating contact, or causing or allowing any person to initiate contact, with potential patients or patients or their personal representatives either in person or by telephone, in an attempt to solicit business.
- (6) Despite subsection (5), a member may advertise by initiating contact with a potential patient or a personal representative of a potential patient if the potential patient does not personally use or consume the gases, equipment, supplies or services that are the subject of the advertisement.
- (7) A member must not appear in, or permit the use of his or her name in, an advertisement that implies, or could reasonably be interpreted to imply, that the professional expertise of the member is relevant to the subject-matter of the advertisement if it is not relevant. O. Reg. 596/94, s. 23.

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<sup>i</sup> How changing patient expectations will impact your practice. <http://practicemanagement.dentalproduct-srepoRT.com/aRTicle/how-changing-patient-expectations-will-impact-your-practice?page=0,1> (July, 2018)

<sup>ii</sup> CRTO Standards of Practice, Standard 1 – Business Practices

<sup>iii</sup> Ibid.



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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