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AIR Waves

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President's Message

Dear Colleagues

The year ahead is filled with possibilities! After lengthy discussion and collaboration amongst the RTSO Board, a decision was made to take hold of new opportunities that would strengthen the Society's voice and presence. As a result, Stephen Laramee has been hired as a Business Manager to investigate feasible opportunities for partnerships and growth. Stephen has an extensive background elevating the stature of non-profit organizations and his leadership will ensure that the Society stays on course when facing the challenges that pertain to these new opportunities. The Board's decision has also proved to be a timely one as Fletcher Wright Associates, our present front office administrator, recently notified us that they will resign their services as of June 30, 2009. As a result of this notification, Stephen Laramee has already assisted the Society in the transition to a new front and back office administration.

These changes also bring a fresh perspective for the Society. They include a broker who has been hired to scrutinize the liability insurance opportunities that exist for our members, the support of a financial auditor who will offer strategic guidance of our fiscal resources as well as a part time Business Manager to facilitate the political presence and direction of the Society. Our current priorities are the establishment of an updated website and improved communication amongst our membership. It is our hope that each of these initiatives will enhance our ability to attract new membership to strengthen our collective voice within the provincial legislation.

The political climate for healthcare is one of innovation and change. It is for these reasons that these decisions have been made. We are committed to our membership to remain at the table ensuring that the legislative decision makers understand the contributions that Respiratory Therapists throughout Ontario provide to ensure excellence in health care delivery. Our goal is to not only maintain but to strengthen our presence through leadership at this table to ensure that the collective voice of each and every Respiratory Therapist is heard.

We look forward to your comments in the year ahead!

Respectfully,

Noreen Chan, RRT
President, RTSO

Renewal Reminder

A reminder that 2009/10 RTSO dues notices have been mailed to all members. Your current RTSO membership and liability insurance expires on June 30, 2009. Please send in your renewal as soon as possible so that your active membership status and liability coverage (if applicable) are maintained.

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From Simulation To Shift Change...The Integration Of Simulation Into Medical Training

Kelly Harrison-Hassall RRT, BSc

It's shift change at Conestoga General Hospital. In the RT back room, the day shift settles down around the report table, pens poised to receive reports. The door opens and in walks the night RT with a report sheet in one hand and a large Tim Horton's coffee in the other. He manages a nod and a "good morning" as he slumps down into a chair, exhausted from the night's events. After a few sips of coffee and a declaration of how happy he is to see them, the night shift RT begins his shift report. The main patient of concern is a 29 year old male who was skiing last night when he hit a tree and ended up with a closed-head injury. After a rough intubation, several scans and a trip to the OR, the patient is now in the ICU. He's likely going to need a retape soon and it would be a great idea to find the end tidal CO2 detector adaptor. As the night RT begins to apologize for not having time to restock the difficult intubation cart or take the bronchoscope out of the steris the pager beeps. It's a stat page to the ICU, the 29 year old male is desaturating.

The day shift RTs, wide-eyed with anticipation, grab their pagers and run down the hall to the ICU. As they enter the patient's room they are greeted by the RN whose voice can barely be heard over the collection of ICU alarms. "Thank goodness you're here, I don't know what's happened but he's desaturating in 100% oxygen and your vent won't stop alarming". At this point it doesn't matter that the night shift RT is actually an instructor, that the hospital is actually in the basement of a College or that the patient is made of plastic. What matters is that these fourth semester respiratory therapy students are about to make a series of real-time clinical decisions and actions with real-time patient consequences and reactions.

It's rare these days to talk about medical training without hearing some sort of reference to simulation. The concept has even gone as far as to be featured in the Grey's Anatomy television series. Exactly what is meant by the term simulation may differ from facility to facility or program to program but the overall objective is the same. How can we use mannequins in a safe environment to enhance student learning and preparation for the clinical environment? The higher fidelity mannequins have become so advanced that not only do they have a pulse, breath sounds and heart sounds, they also have the ability to respond in real time, breathe out CO2, analyze the effectiveness of bag and mask ventilation and transition into Vtach as a result of inadequate respiratory support. Their tongues swell, their pupils react and their work of breathing can change. Educators couldn't ask for a more compliant volunteer to augment learning in a simulated environment!

Whether it is a veteran RT preparing for their role on the Critical Care Response Team (CCRT) or a second year RT student preparing to head out for their clinical rotation, simulation is a wonderful tool that can be used to reinforce and practice skills that have been discussed in a lecture format, read in a book and practiced in a traditional lab setting. The challenge is to discover the best way to integrate this tool into our present curriculum. When should the simulation training begin? What kinds of environments is it best suited for? How many National Competency Profile objectives can be achieved in a simulated setting? What is the benefit to using high fidelity simulation in CCRT or ACLS training? What are the associated costs to developing and maintaining a high fidelity setting? These are all questions that RT as a profession needs to consider and explore as we continue to integrate simulation into our clinical training.

Fletcher Wright Associates Inc… Where to Begin?

The RTSO and its administrative provider, Fletcher Wright Associates Inc. have mutually agreed that each organization needs to seek new directions and opportunities. As a result, despite what has been a rewarding partnership experience, another chapter will close for the RTSO. The RTSO board wishes to express its sincere gratitude to Fletcher Wright Associates Inc. for their years of outstanding service. Shane Donaldson, a past president of the RTSO, has graciously written a brief memoir that details the value and asset that this partnership has provided for the RTSO.

I must admit I do not remember the exact timing when Fletcher Wright Associates Inc. became our office managers, mentors and helping hands but it's been nearly as long as I have been involved with the RTSO. The Fletcher Wright staff, Leslie, Nikki and Stuart, have each been through thick and thin guiding the RTSO for nearly as long as our organization has existed.

Leslie mothered us through very difficult times, times when the RTSO barely had two nickels to rub together. This was evident during my initial presidency when I inherited a Society with a membership of approximately 50 respiratory therapists and nothing in the bank. It was our good fortune that Fletcher Wright was there as we began to rebuild the Society. Leslie had faith in us, stood by us and allowed us to pay for her services when we could and at rates much less than their other clients. Nikki, who was initially in the shadows, eventually took over the reins from her mother and has matured into the efficient operative that she has become.

Partnering with Fletcher Wright was an interesting and intriguing opportunity. Prior to this, the Board ran most, if not all, activities from their homes or hospital offices. The decision to choose Fletcher Wright was unanimous when the board felt we had finally matured and needed a permanent address versus changing our address every time we elected a new president or secretary. At the time of that transition, we gave to Fletcher Wright, what could be considered by most, as the ugliest filing cabinet that you have ever seen. It was an old, green metal goliath discarded, if I remember correctly, from TGH. It was painted blue, orange and yellow. I remember it vividly since I had the pleasure of it occupying a spot at my home in Ajax when it was given to me following Rob Leathley's move to New Brunswick. As a result, it became of a focal point of my basement décor and a pinnacle of my surroundings but one that was easily surrendered.

Fletcher Wright was also there when we made our stance with the CRTO and I am certain they had as many perspiring brows, migraines and near nervous breakdowns as we did when the costs began to mount. The affiliation that now exists between the CRTO and the RTSO is a testament of the working partnership that we shared with Fletcher Wright and the resolve that co-existed to develop a better relationship with our regulatory body.

During the latter years, Fletcher Wright posted Stuart to the role of overseeing the operation of the RTSO. His assistance over the last few years has made him the face of the RTSO at many conferences and meetings. Behind the scenes, Leslie continued to attend our educational forums and when either Nikki or Stuart was unavailable, she would provide the necessary secretarial support.

It has been a long and mutually beneficial history. Personally, with a tear in my eye, I express my sadness to see this relationship end but I understand and respect that we (Fletcher Wright and the RTSO) must move on and in our own directions. I offer my best wishes and respect to Fletcher Wright and the individuals from their office who took part in rooting the foundation of what the RTSO envisions for the future.

Thank you
Shane Donaldson
RTSO Past President

New Contact Information for the RTSO Office

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Threats to the Profession

The RTSO is bringing this article to your attention recognizing that Ontario's health care system functions differently than the US model, there are never the less poignant points raised to which Ontario RTs would be wise to consider.

Laher DS. Threats to the Profession: Scared About Nursing--Think Again. RT: For Decision Makers in Respiratory Care. 2007;20(3):18-23. Copyright 2007. Ascend Media. Reprinted with permission.

In some institutions, nurses are taking on the chores of RTs, but nursing is not the only threat to the profession.

It was 11:30 pm on Sunday night, and, as usual, the emergency department (ED) was swamped. The waiting room—littered with outdated copies of People magazine, soda pop, and snacks from the vending machine—was filled with angry patients waiting to be treated.

"I've waited for 6 hours and still haven't been seen by a doctor yet!" one man yelled.

"Please be patient, we'll get to you as soon as possible," the triage nurse replied.

The ED had patients in not only every bed space, but on gurneys in the hallway as well. With the rest of the hospital equally busy and no monitored beds to be found, the ED was placed on diversion: Its doors were closed to all emergency traffic, a strategy that would be reevaluated in 2 to 4 hours.

With a nursing vacancy rate in the ED alone of more than 10%, two call-offs only added insult to injury. The ED staff were barely keeping their heads above water.

At that moment, a man with severe asthma stumbled through the door. Blue—and barely able to breathe—the man managed to whisper three words to the nurse before he plopped down in the chair. Exhausted, he said, "I can't breathe!"

The nurse knew immediately who to call—Brian, who had bailed her out hundreds of times before with respiratory patients. He saw that if he did not get this patient started on some heavy-duty bronchodilators, the prognosis would not be good.

Calmly, Brian put the patient into a wheelchair and took him back to the examination room. He stabilized the patient with a 7.5 mg dose of albuterol and approached the physician with the suggestion of starting the patient on IV steroids to aid in his recovery. After 45 minutes of aggressive therapy, a trip to radiology for a chest film, and thorough education on the management of asthma, the patient was discharged and sent home. Had it not been for the skill and expertise of Brian, the patient's outcome could have been a lot worse.

RTs face similar situations in EDs across the country; and therapists across the globe have been in Brian's shoes before and have taken great pride in knowing that when it comes to patients with cardiopulmonary deficiencies, they are the most qualified clinicians to provide care. RTs are the experts—a fact with which it is difficult to argue. Unfortunately, in this particular scenario, Brian is not an RT and not a nurse; he is, rather, an emergency medical technician (EMT).

How Did This Happen?

The notion of someone other than a respiratory therapist providing care to patients with breathing problems is preposterous. After all, in the early 1980s, under the retrospective payment system, there would have been no way a hospital administrator would have allowed anyone other than an RT to administer an aerosol treatment. Respiratory therapy departments were the cash cows of hospitals.

In the 1990s, with the prospective payment system thoroughly in place, hospitals relied on the delivery of more efficient, cost-effective health care as a means to combat added costs. The advent of therapist-driven protocols and more responsibility being placed in the hands of RTs demonstrated that hospital administrators understood the value of a therapist at the bedside. With RTs acting as extensions of the physicians, reduced costs and hospital length of stay were the norm.

Over the past 20 years and more, diagnosis-related groups have changed the landscape of health care. As health care moves into the 21st century, however, hospitals need to worry about more than costs: Now they must be concerned about how to provide care to patients with national nurse vacancy rates of 8.5%[1] (118,000 vacant positions), an aging workforce, and the anticipated surge of patients as a result of an aging Baby Boom population. For this reason, hospitals are looking at ways to change the paradigm in which health care is provided. The concern of many has always been the fear that nurses or nursing assistants would be the likely candidates to assume the responsibilities of an RT. Realistically speaking, however, with the nursing shortage that plagues the country and the continued expansion of nursing responsibilities, nurses are no longer positioned to perform respiratory procedures. Anticipating that the nursing shortage is only going to get worse (an additional 1.2 million nurses will be needed by the year 2014[2]), hospitals are forced to find the "health care provider of tomorrow"—a nurse extender if you will; one who is cross-trained to perform in all aspects of the health care environment.

Why EMTs?

The National Highway Traffic Safety Administration (a division of the Department of Transportation) has set standards for three levels of EMTs. Each state has the option of either adopting the DOT standard or adopting its own. In the "prehospital" environment, the first level of EMT is called the EMT-Basic. The technician achieves this credential after roughly 140 hours of classroom and hands-on training.

The second tier of EMT credentialing is the EMT-Intermediate, which requires roughly 80 hours of classroom time and 80 hours of field experience. Under the watchful eye of another EMT-Intermediate/Paramedic, it is at this level that the EMT becomes authorized to deliver oxygen, insert IVs, and employ advanced airway devices. In some states, EMT-Intermediates are permitted to deliver some medications that EMT-Basics are not.

The highest tier of the EMT is the EMT-Paramedic, which is recognized in all 50 states. Although the training varies from state to state, it usually comprises 1,500 to 2,000 hours of study. As caregivers in the field, EMT-Paramedics are considered by many to be no different than physicians. Paramedics are trained to perform numerous procedures that EMT-Basic/Intermediates are not and also are authorized to deliver many more levels of medications than their lower-level counterparts.[3] The EMT-Paramedic is highly sought after to treat patients in the field, where their superior training and clinical expertise provide added value to fire departments and communities across the country.

As a result, many lower-level EMTs (typically EMT-Intermediates) are coveted by hospitals to staff their EDs. Unlike most respiratory therapy departments, which (because of productivity restrictions) are unable to provide around-the-clock care in the ED, EMTs are available to provide immediate interventions, without the delay of having to page an RT. With significantly less formal education—the minimum requirement is a high school GED—EMTs are far more abundant and more affordable than nurses and RTs. In addition, as most emergency departments are classified as "prehospital," the scope of practice of most EMTs allows them to perform any procedure or deliver any medication that they would be able to do in the field. Under the guidance of a licensed caregiver or physician, the return on investment of an EMT is extraordinarily high. Although the presence of an EMT contributes to a favorable financial picture for an organization, the question still remains as to whether they can provide the same level of patient care as their more educated, trained, and experienced counterparts.

Can They Do the Job?

Without question, EMTs bring a considerable amount of expertise and skill to the aid of patients with varying levels of medical necessity. While in the field, life and death often lie in the hands of EMTs. Their decisions make the difference between a trip to the hospital and a trip to the morgue. Their value is undeniable and most certainly plays a role in the care of patients in the field.

There is, however, a disadvantage to being a "jack of all trades, master of none." Because an EMT does not have specialization in one particular area, there will always be specialists who bring more expertise, a higher skill level, and more knowledge to the table. This is the case when comparing the skills of an EMT to those of an RT.

Airway management, for example, has always been the staple of respiratory therapy. It is standard practice by most EMTs that, when managing a patient's airway, their most common selection is a laryngeal mask airway (LMA). It is easier to insert than is an endotracheal tube and is highly effective for patients requiring short-term airway management. Endotracheal intubations require far more expertise, leaving success rates for EMTs documented as low as 50%.[4]

For respiratory therapists, therapist-driven protocols are the hallmark for patient care in both the inpatient and ED settings. Probably the most com-

monly used protocol in hospitals is that of oxygen implementation, titration, and discontinuation. While the EMT is well trained at initiating oxygen, their skills lag considerably when it comes to weaning and discontinuation.[5]

Nurses Should Be Scared Too!

Respiratory therapists are not the only health care providers who should be concerned about the increased utilization of paramedics and EMTs in the emergency department and inpatient settings. In January 2007, the Virginia General Assembly passed senate bill 1324 by a unanimous vote of 14-0. The bill authorizes licensed paramedics to engage in the practice of professional nursing and to perform the duties associated with the practice of a registered nurse or a licensed practical nurse. Sponsored by Ken Cuccinelli (R–District 37), the bill also exempts licensed paramedics from the licensure requirements applicable to nurses.[i] Although opposed by the Virginia College of Emergency Physicians,[ii] this landmark case could easily pave the way for similar changes in licensure requirements across the country.

References

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ii. Virginia College Emergency Physicians. Available at: www.vacep.org/Legislation/2007LegislationList.htm. Accessed February 7, 2007.

Although the financial considerations for staffing EMTs in the emergency department are significant, their utilization should be carefully considered. The Centers for Medicare and Medicaid Services (CMS) already requires hospitals to publicly share quality data specific to many disease states, most notably, congestive heart failure and pneumonia. The reasoning for this, and the belief by many, is that reimbursement to hospitals will soon be based on outcomes, or pay for performance. Therefore, sacrificing high quality for the sake of saving money may very well render the hospital penny wise, but dollar stupid.

What's an RT to Do?

When utilized appropriately, the value that an RT adds is monumental. Physicians and hospital administrators who do not understand or appreciate this fact typically make regrettable decisions to replace RTs with EMTs. As caregivers, it is the job of RTs not only to ensure that the highest level of care is provided to the patients, but also to be advocates of the profession. There are many strategies to ensure that the most competent and skilled clinician is at the bedside for the care of patients with cardiopulmonary disorders and also to strengthen and maintain the role of the RT in the health care environment.

Document Outcomes

One of the primary reasons decisions are made to either minimize the role of the RT, or decentralize departments altogether is that key decision-makers are unaware of or underestimate the value of the RT. That is why all departments should document clinical outcomes. Whether it is response time, admission data for patients with respiratory-related diagnoses, or the financial comparison of patients who, with the expertise of an RT, can benefit from non-invasive ventilation versus endotracheal intubation, this information (when in the hands of the right person) is invaluable.

Satisfaction scores provide important information regarding the patient experience. Physician satisfaction scores assist in driving volume through the doors of the hospital. Data regarding the performances of RTs should be collected and compared. If physicians and administrators feel patients value RTs, chances are that they too will gain a newfound appreciation for them.

ED wait times, admission, and readmission data are also invaluable pieces of information that can work in favor of RTs. When utilized appropriately and given proper autonomy, therapists can minimize therapeutic frequency through more aggressive treatment methods, reduce inpatient admissions by providing undelayed care, and—perhaps most important—by sharing their expert knowledge, can provide patients with the education required to avoid future readmissions. All of this data widens the margin of profitability and enhances the likelihood of therapists remaining in the emergency department.

Dollars and Sense

As licensed and credentialed caregivers, RTs are legally able to bill for services rendered. Billing practices become fraudulent if nursing personnel or EMTs attempt to bill for the same services. Thus, in small rural hospitals, utilizing the skills of an EMT to perform such procedures could result in a loss of as much as $200,000 per year. For larger academic institutions and level I trauma centers, this could be more than $1 million per year. Eliminating the role of the RT by expanding the role of the EMT might assist in solving the nursing shortage problem, but does not come without a hefty price tag.

Protocols and Expanded Responsibilities

The benefits of therapist-driven protocols are well documented.[6-8] Whether addressing the reduction of misallocated care or shortened length of stay, protocols have proven themselves to be beneficial to both patients and hospitals. Utilizing protocols to enhance and expedite care in the ED appears to be a logical choice.

Consider what the scope of respiratory therapy would be if every department considered utilizing RTs in unconventional ways. Think for a moment how the role of RTs would be enhanced if they were to routinely perform such procedures as peripheral vein phlebotomies and Foley catheter or oral-gastric tube insertions; measure vital signs; do 12-lead ECGs and point-of-care testing; and apply sutures and sterile dressings or splints. In some hospitals, RTs perform arterial and PICC line insertions, as well as manage IABP and ECMO equipment. Some states also allow RTs to perform conscious sedation in controlled situations. If these procedures (and possibly others) were employed as standards of care by RTs, think of the value they would bring to hospitals and EDs alike. Instead of a cross-functional EMT, imagine a "Super RT" who would perform hybrid-like responsibilities of a respiratory therapist, nurse, and physician. Farfetched as it may sound, these are all viable and realistic therapeutic options when it comes to staffing RTs, not only in the ED, but in intensive care units and and on medical/surgical floors as well.

Professionalism

For years, RTs have fought to gain the respect and recognition of the medical community, and the American Association for Respiratory Care has supported lobbying efforts in Washington to achieve this goal. Whether it is reimbursement for outpatient pulmonary rehabilitation or home health care, recognition of RTs as "professionals" is paramount to the success and longevity of the profession.

Unfortunately, the apathy and bickering that takes place within our own ranks are a detriment to our success. Arguments over professional membership, RRT versus CRT, or a bachelor's versus an associate degree are clear examples of this.

One thing, however, that is undeniable is the perception that other members of the health care community have of the respiratory therapy profession. Fair or unfair, it is that same perception that leads physicians and hospital administrators to believe that EDs would be better served having EMTs perform the duties of an RT. It is imperative, now more so than ever, to take this profession to new heights. Become a registered respiratory therapist (RRT), a neonatal pediatric specialist (NPS), or gain the ACLS, PALS, or NALS credential. Become an asthma educator (AE-C); participate in hospital-sponsored journal clubs, mock codes, or research opportunities. It is the right thing to do, for the patients and for the profession. It is actions such as these that will gain RTs newfound respect and will solidify the role of the RT in the ED and beyond.

Threats to the profession are a reality. With staffing shortages nationwide, decreased reimbursement, and a capitated work environment that diminish profitability, hospitals will most certainly look at opportunities to save costs. Pacesetters will look at changing the culture and paradigms in which health care is provided. Respiratory therapy, as with all health care professions, will be under the microscope. Respiratory therapists need to keep in mind that there are other professions willing and waiting for the opportunity to perform respiratory-specific responsibilities. As threats to the profession become more and more a reality, RTs must be prepared to look at themselves in the mirror and ask themselves the question, "Scared About Nursing?" And answer, "Think Again!"

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Awards

The RTSO is pleased to be able to provide three different awards for members. These awards highlight dedication and achievement by members. In considering someone for these awards, you are providing the profession reflection on all that we can do. Please review the criteria and nomination forms on our website and consider someone you know for one of these awards. All entries are due August 1st, 2009.

STUDENT ACHIEVEMENT AWARD

The Respiratory Therapy Society of Ontario (RTSO) Student Achievement Award is given each year to a graduating student from one of the accredited programs in Respiratory Therapy in the Province of Ontario who has demonstrated outstanding professionalism during their clinical training.

THE PINNACLE AWARD

The Pinnacle Award is a premium award, awarded only to a Respiratory Therapist in Ontario who has contributed to the profession in a unique manner.

THE GORD HYLAND MEMORIAL LEADERSHIP AWARD

This award was established to recognize Gord Hyland and all of his contributions to the profession of Respiratory Therapy. The candidate should be chosen for their great leadership skills, and should exemplify many of the characteristics we saw in Gord.

Education Forum 2009

Friday September 25 evening: Wish to meet you, Wine and Cheese
Saturday September 26, 2009 in Niagara Falls, at the Sheraton on The Falls Hotel

This September marks the fifth year of the annual RTSO education forum. I am confident that each year the forum is better than the last. Not because we have better topics or speakers, our speakers have done an outstanding job each year but because of therapists like you. Individuals who believe:

- that there is value in having a professional presence in the province
- that networking with colleagues, vendors and friends enriches their professional experience
- that there is something to be gained when therapists collectively come together to learn

Last year an attendee commented “this has been the best RTSO education forum yet”. So why not check it out this year. Saturday September 26, 2009 in Niagara Falls, at the Sheraton on The Falls Hotel.

We have an interesting and varied outline of topics and presenters organized in four themes Leadership, Neonatology, Anesthesia and Alternative Long Term Ventilation Strategies.

This forum is planned for every Respiratory Therapist in Ontario. You don’t have to be an RTSO member to attend. I am confident that after attending the forum individuals who are not members of the RTSO will recognize the value of our organization and choose to become a member.

So mark it on your calenders tell your colleagues. Looking forward to meeting you!