Initiative 6 Allied Health

Project 6.3 Scope of Respiratory Therapy

Final Report

December 2004
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Executive Summary

The July 2002 Deloitte and Touché (D&T) External Review noted that Respiratory Therapy (RT) staffing levels in the critical care units at St. Boniface General Hospital (SBGH), Health Sciences Centre (HSC), Victoria General Hospital (VGH), and Grace General Hospital (GGH) were below peer levels. It was recommended that the critical care delivery model be redesigned to include an enhanced role for respiratory therapists to work at a higher level within their scope of practice.¹

To achieve the goal of an increased RT role within the health care team, the project team assessed the practice of respiratory therapy by:

- Reviewing the scope of practice of the respiratory therapy profession in Canada and identifying gaps between Winnipeg and national levels
- Reviewing the literature (XIII. References)
- Conducting multidisciplinary focus groups within the region (Appendix 1)
- Administering a survey regarding RT role and scope within the Winnipeg Regional Health Authority (WRHA) and across Canada; duties currently performed by RTs were listed by program area and by job classification
- Visiting St. Joseph’s HSC in London, Ontario to gain additional insight into RT practice and responsibilities at a best practice site as identified by D&T

An RT practice model reflecting a higher level of practice has been drafted based on the project findings (IX. Model for Respiratory Therapy Practice). This model includes a detailed listing of recommended RT services by program area (Appendix 4), provided RT is appropriately resourced to do so on a consistent basis.

A multi-year implementation/reinvestment plan has been developed (X. Multi-Year Implementation Plan) identifying specific areas requiring reinvestment and the rationale for the proposed changes.

The model and supporting plan were drafted in consideration of the current fiscal environment, regional program priorities, available and anticipated resources, and underlying principles established for the RT model. The plan lays the groundwork for long-term change to the RT Clinical Support Program as recommended by the ABC Allied Health Infrastructure Project 6.1.²

Next steps include the development of consistent practice standards, guidelines, and job descriptions that will further support the model in all areas across the region. Full integration of respiratory therapists to enable the provision of enhanced respiratory care is consistent with the WRHA mission, values, and principles of prevention and promotion, treatment and support, working with community, working with staff, and accountability.

Recommendations

The Project Team is seeking approval in principle for the recommended changes and requests funding for this project be given high priority to enable the initiation of a staged implementation.

1. The proposed Allied Health organizational structure, particularly as it relates to the Respiratory Therapy Clinical Support Program, be implemented at all sites within the WRHA as recommended by the Allied Health Infrastructure Project 6.1.²
Rationale
• Facilitates the implementation of the new model for RT practice
• Improves the ability to implement efficiencies in the delivery of RT practice across the region
• Enables the provision of enhanced quality and consistency of care

2. The proposed priorities and multi-year plan for RT reinvestment be accepted. Areas identified at present requiring reinvestment include:
• Critical Care and Emergency
• Inpatient Wards
• Site and Regional Clinical Specialists and Site RT Managers (where required)
• Regional RT Manager for Acute/Community Care
• Child/Women’s Health
• Regional RT Float pool

Rationale
• Provides immediate returns by improving patient outcomes and decreasing costs related to length of stay and hospital readmissions (Reinvestment in the region was identified by D&T as an immediate 16.5 EFTs - RTs more than 25% lower than peer comparator mid-point, with subsequent 34.0 EFTs for a total of 50.5 EFTs to achieve the 50th percentile of benchmarked sites, recalibrated to 53.4 EFTs based on 2002/03 data)
• Supports WRHA regional priorities for improved resource utilization and delivery of patient care
• Aligns with D&T recommendations regarding nursing and RT workload
• Supports identified RT regional program needs including enhancement of RT services in the community and long term care
• Lays the groundwork for long-term change to the RT Clinical Support Program, consistent with the Allied Health Infrastructure Project 6.1

3. As resources are made available, implement the proposed RT model of practice to allow RTs to work within full scope of practice.

Rationale
• Improves patient clinical outcomes
• Decreases risk management/patient safety issues
• Provides more efficient use and distribution of resources
• Improves job and work life satisfaction
• Improves continuity of care
• Decreases gaps in service
• Facilitates best practice and consistent standards of care
• Facilitates management of overtime/relief issues using tools such as a regional float pool
• Facilitates consistent definitions of clinical and management roles and development of standardized job descriptions
• Facilitates sharing of respiratory clinical specialists and educational resources
ABC PROJECT 6.3

RESPIRATORY THERAPY
SCOPE OF PRACTICE
I. Background

Respiratory therapists (RTs) possess the knowledge, skills, and abilities to provide a comprehensive range of therapeutic and diagnostic procedures to patients requiring basic and advanced cardiopulmonary and related services.

Working across the health care continuum, RTs work closely with physicians and other health care staff to develop and carry out individual patient care plans. Respiratory therapists provide complex therapy requiring considerable independent judgment, such as caring for patients on life support ventilators. As a member of the patient care team, RTs assume primary responsibility for all respiratory care including therapeutic treatments and diagnostic procedures.

Registered respiratory therapists are graduates of accredited educational programs and are registered and licensed with the Manitoba Association of Registered Respiratory Therapists (M.A.R.R.T.). Respiratory therapy practice is governed by guidelines prescribed through Standards of Practice, ethical conduct codes, institutional policies, and legal requirements.3

Respiratory Therapy in Manitoba

The Winnipeg region employs over 150 RTs across the nine health care centres. Over 6,600 RTs are currently employed in Canada. Manitoba’s 190 RTs account for 2.9% of all RTs employed in Canada.4

Only 29% of Manitoba RTs are involved in community health promotion, giving Manitoba the lowest participation rate in Canada, compared to an average of 53% across the country. Manitoba RTs are also under represented in other areas such as discharge planning.4

Deloitte and Touché External Review Findings

The July 2002 Deloitte and Touché (D&T) External Review noted that:

“The Respiratory Therapy staffing levels in the critical care units at SBGH, HSC, VGH, and GGH are below peer levels directly impacting the workload for the nursing staff in these units. For SOGH and CH, the respiratory levels appear to be in line with peer units.”

In addition, D&T stated:

“The (critical care) delivery model should be redesigned and include an enhanced role for the Respiratory Therapist to work at a higher level within their scope of practice. This will require considerable education for nursing staff about the scope of practice for RTs.”

In response to these recommendations and long-standing issues of concern, the ABC Respiratory Therapy project goals were determined:

Project Goals

1. To create and implement a plan to support a delivery model for an enhanced role for RTs utilizing a full scope of practice that fully integrates the RT into the health care team in adult and pediatric community care, acute care, and long term care (LTC).
2. To improve staffing efficiencies in critical care and other program areas through an enhanced RT role and scope of practice.

3. To provide an improved work environment for RTs and other health care professionals providing direct patient care.

It is anticipated that the achievement of these goals will facilitate the discipline's active and meaningful participation in health care delivery and will provide support to the WRHA Strategic Plan, Mission, and Vision.
II. Respiratory Therapy Scope of Practice

Scope of practice can be described as the range of roles, functions, responsibilities, and activities that RTs are educated and authorized to perform. Generally, the actual range of duties is narrower than that of the scope of the profession as a whole, influenced by the practice setting, patient needs, and requirements of the employer.

RT programs in the nine WRHA sites and eleven national sites were surveyed to identify duties performed.

Sites surveyed included:

**Ontario**
- London: St. Joseph’s HSC London Health Sciences, University Campus
- Mississauga: Credit Valley Hospital
- Scarborough: Scarborough Grace Hospital
- Toronto: Sunnybrook Hospital
  - Women’s HSC
  - Women’s Centre Hospital for Sick Children

**Saskatchewan**
- Regina: Qu’Appelle Health Region
- Saskatoon: Royal University Hospital

**Alberta**
- Calgary: Foothills Hospital
  - Peter Lougheed Hospital
  - Rockyview Hospital
- Edmonton: University of Alberta Hospital

**British Columbia**
- Vancouver: British Columbia Children’s
  - Women’s Health Centre of British Columbia

The site survey reviewed the diverse roles and responsibilities of the respiratory profession in a variety of sites across Canada. The findings of the survey identified gaps between Winnipeg and the surveyed sites, reflecting a higher level of practice in other regions. These findings are consistent with the proposed model for implementation (IX. Model for Respiratory Therapy Practice).

Scope of Respiratory Therapy practice, as outlined in The National Alliance of Respiratory Therapy Regulatory Bodies National Competency Profile, include competencies within the broad areas of:

- Exhibits professional behaviour
- Communicates professionally with patients, families, colleagues, and health care professionals
- Evaluates using principles of critical thinking
- Applies measures to prevent and control infections
• Applies principles of research in assessment of learning
• Participates in research
• Educates patients, families, colleagues, and health care professionals concerning respiratory care
• Applies principles of administration/management
• Conducts patient assessment
• Provides consultation concerning patient care to colleagues and health care team members
• Procures and analyses blood samples
• Performs pulmonary and cardiac diagnostic testing
• Performs hemodynamic monitoring
• Performs basic respiratory care procedures including oxygen therapy, humidity treatment, suction therapy, aerosol therapy, sputum collection procedures, thermal regulation procedures, pulmonary rehabilitation, breathing techniques, incentive spirometry, etc.
• Performs airway management techniques including intubation and extubation
• Optimizes pulmonary ventilation
• Applies medical gas therapy
• Performs anesthesia assistance
• Assists in maintaining cardiopulmonary stability including dysrhythmia recognition/interpretation, defibrillation, resuscitation, etc.
• Administers pharmacological substances
• Transports patients via ground/air
• Maintains and repairs respiratory care equipment

Competence refers to the ability of the RT to integrate and judiciously apply the required knowledge, skills, attitudes, and judgment for performance in a designated role and setting.6

Shared competencies are activities within the scope of practice of multiple disciplines, performed by professionals competent in a skill and endorsed to do so through facility policy.7

Appendix 2 includes a detailed listing of specific Canadian Respiratory Therapist competencies within scope of practice. Respiratory therapists share some of these competencies with nurses, physicians, and other health professionals.

Areas of overlap exist between and among the individual scopes of practice of various health care professionals.6 Each discipline that shares skills also makes its own unique contribution to the collective care of the patient.7 Practitioners sharing areas of common ability and expertise have roles, relationships, and responsibilities in patient care characterized by flexible, overlapping scopes of practice. The decision making process used to assign a skill or role to a particular health care professional must recognize the unique and shared competencies of all professionals and promote optimal and complimentary use of their skills, knowledge, and judgment in the interest of safe patient care.8,9

Employer decisions regarding which professionals provide service in areas of shared competency must consider patient/family needs and best interests, best practice research, context of practice, and availability of educational support and practice competency resources.
(i.e. the frequency at which the procedure will be required in the practice setting and opportunity to maintain competence).\textsuperscript{8}

Collaborative decision-making, conducted in an atmosphere of trust, involves mutual respect for one another’s knowledge, expertise, competence, open communication, mutual agreement, and inter-referral when appropriate. Formal documentation of collaborative scope of practice decision-making is required, through multidisciplinary policies and practice guidelines consistent with professional competencies and legislated scopes of practice.\textsuperscript{10, 11}

**Focus Group Findings Related to Scope of Practice**
The current lack of RT presence in Winnipeg hospitals has resulted in a misunderstanding of respiratory therapy practice and competencies and has impacted on nursing workload; this is not limited to critical care areas.

Focus groups held in November 2003, with nursing, physician, and RT representatives from all WRHA sites confirmed:

- A lack of understanding exists among health care professionals of the breadth and depth of RT education and training
- The need to educate the health care team about the competencies of RTs
- Recognition of the RT role in education, ventilator management, management of emergency codes, and tracheostomy care
- Strong support for an increased RT role in patient and staff education
- That the extent of shared duties is site specific (e.g. in tertiary sites, residents, interns, and students compete with RTs for opportunities to develop/maintain complex clinical skills)
- That RTs support a more active and proactive role in patient care including an enhanced presence by RTs in patient care rounds
- The need for more active involvement in chronic respiratory care, in Emergency Departments, on wards, and on the night shift
- That the lack of support and timely response by RTs is largely due to deficiencies in RT resource levels

The complete summary report of focus group findings is included in *Appendix 1*. 

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III. Respiratory Therapy Role

The Deloitte and Touché External Review highlighted the need for an enhanced role for the RT in critical care. There is support in the literature for a model wherein dedicated ICU personnel, specifically the physician, nurse, respiratory therapist, pharmacist, and other health care professionals all work as a team.\textsuperscript{12}

Respiratory therapists, having specialized knowledge of the principles of respiratory management, should have a continuous presence in the ICU.\textsuperscript{12, 14} In the Winnipeg region this is currently not possible, as the RT faces competing demands for service to other programs.

The importance of RTs in facilitating weaning from mechanical ventilation and improving the allocation of respiratory care services has been well documented. Current evidence suggests that respiratory therapist-directed ventilator weaning, via protocol, results in a shorter duration of mechanical ventilation and length of ICU stay compared with traditional physician-directed weaning. Additional benefits include improved efficiency, reduced costs, decreased complications, reduced mortality, and reduced re-intubation rates. These trials represent prospective, randomized, controlled trials in single institutions using concurrent controls and clearly demonstrate the value of integrating respiratory therapy into the health care team in the ICU.\textsuperscript{12, 13, 14, 15}

The Muse Study, commissioned by the American Association for Respiratory Care in 1999, examined the differences in costs and clinical outcomes between Medicare patients (over 65 years of age) who received respiratory services from a RT and those who did not. The study was conducted in skilled nursing facilities in the USA (LTC, chronic care, and rehabilitation patients). Patients treated by a RT had a 42\% lower mortality rate at their next encounter with the Medicare system than a similar group of patients who received care from non-RT caregivers. The study concluded that RTs saved Medicare approximately $98 million US in 1996. On a per capita basis, costs for patients who had not received respiratory care by RTs were 11\% higher than for patients treated by RTs. Patients treated by RTs had a shorter length of stay by 3.6 days and 31\% more non-RT-treated patients subsequently returned to a hospital ER or outpatient department after their initial stay.\textsuperscript{16}

The effectiveness of RTs in improving patient outcomes and decreasing costs when empowered to use clinical practice guidelines and RT driven protocols is increasingly validated in the literature.\textsuperscript{15, 16}
IV. Impetus for Change

Deloitte and Touché Recommendations

A lack of respiratory therapy resources has been a long-standing concern, validated by a variety of internal and external reports over the last five years. D&T addressed adult critical care noting that insufficient RT resources has resulted in less than full respiratory support by RTs, impacting nursing workload.

D&T recommended that areas more than 25% lower than peer comparator mid-point receive immediate reinvestment to reduce the gap to only 25% below the midpoint. At the time of the review, an immediate reinvestment of 16.5 respiratory therapy EFTs was identified to bring RTs to the 25th percentile of comparator sites.

An additional 34 EFTs are required to achieve the 50th percentile of benchmarked sites, for a total of 50.5 EFTs (recalibrated to 53.4 EFTs based on 2002/03).

The 50.5 EFTs were intended to cover RT services to all areas in acute care facilities, not just critical care. The Respiratory Therapy Scope of Practice project team has identified areas for reinvestment including; Child/Women’s Health, Emergency Departments, and tertiary site wards. The team also recognized that while Long Term Care and Community Care were not included in the original D&T review, some specific gaps in service and continuity of care require investment. However, further support to these areas is beyond the scope of this project and will be reviewed by the RT Clinical Support Program in collaboration with stakeholders.

Critical Care

Respiratory therapists in the Intensive Care Units across the Winnipeg region are under-utilized and under-resourced. This is exceedingly apparent at the HSC. Not only is there significant under-utilization of the RTs at HSC, they are under-staffed to a point where they cannot maintain their current workload. Findings of this project discovered that other Intensive Care Units in Canada (similar to the HSC in size and acuity) employ two RTs around the clock exclusive to their unit. Respiratory Therapy should be provided on a consistent, routine basis, throughout the region. RTs should be available to the ICU 24 hours a day, seven days a week without competition from other programs.12, 13

RTs are well qualified to manage airways including intubation (inserting and managing endotracheal tubes), extubation, suctioning, etc. to optimize pulmonary ventilation.

Arterial line insertion and maintenance, arterial blood gas sampling and analysis, participation in patient rounds, inhaled medication delivery, and medical gas therapy should be routine activities for RTs in ICUs. RTs can also be involved in areas such as metabolic studies in collaboration with dietitians, a practice which has proven to reduce ventilator days. Ongoing RT presence in critical care areas would alleviate stress and workload for physicians and nursing. It has also been proven that when RTs provide enhanced service, patient outcomes improve, and costs are reduced.12, 13, 15
Emergency Care

Respiratory therapy is under utilized in the Emergency Department (ED). RT involvement on an ongoing basis would allow nurses and physicians to focus on their core functions.

There are site-specific gaps that need immediate attention. The HSC, as the major tertiary trauma centre for Manitoba, should have continuous RT services. This would provide specialized patient care and expertise currently not available on a consistent basis and would result in substantially improved patient care.

Increased RT resources would result in decreased wait time for diagnostic testing, for example point of care blood gas analysis with electrolyte/metabolite capabilities, and would improve the ability of the RTs to respond to patient’s needs, e.g. asthma education, COPD education, etc.17

Hospital Wards

The transition of patients from the ICU to the ward is associated with high mortality.19 RTs are well qualified to assist with the transition and assist in early recognition of the seriously ill thus preventing potentially serious events. Ongoing RT support on the ward would enable therapists to provide COPD, asthma, and home oxygen teaching to patients and families. Oxygen titration reduces costs and has been demonstrated to decrease length of stay. Tracheostomy care on the wards could potentially enable patients to leave the ICU sooner and reduce readmission to the ICU. The inclusion of RTs in patient rounds and discharge planning can impact length of stay.

Child/Women’s Health

HSC Child Health RTs provide coverage to both Children’s Hospital and the Women’s Centre. Because of inadequate RT staffing, consistent and timely coverage to all clinical areas within Children’s Hospital and the Women’s Centre has not been possible. The Women’s Health component, included in D&T adult calculations, has a shortfall of approximately 1.6 EFTs plus relief to provide appropriate coverage at HSC.

Pediatric and neonatal intensive care units appear to be adequately staffed at benchmark. RT presence in the Children’s Hospital Emergency Department and wards is almost non-existent, with service essentially being limited to Code Blue response. The asthma care map identifies the key role RT plays in appropriate asthma management, but due to lack of resources, respiratory therapy skills and expertise in asthma management are significantly under utilized at Children’s Hospital.

With current RT staffing levels, Child Health requirements for RT service, negatively impacts coverage to Women’s Health. Coverage for neonatal transport is provided out of baseline staffing on day shifts and on-call (non funded) at night. The result is that during a transport on days, RT services function below baseline. This is compounded further if simultaneous transports occur on days or nights. RT night coverage is limited to one RT for all of Women’s and transport coverage, one RT for NICU, and one RT for PICU. Staff often face competing demands for services across the site.

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Children’s Hospital and the Women’s Centre are faced with potentially dangerous situations caused by the shortfall in RT coverage. The lack of RTs has resulted in recent, documented occurrences of delayed response times to codes and high-risk deliveries delaying advanced airway/ventilation management. Neonates and infants are at risk for increased complications due to prolonged hand ventilation in the absence of RT resources.

HSC Women’s Centre Critical Care area requires 24/7 RT coverage to reduce risk and allow enhancement of scope of practice.

Recommended changes include:
- Institute Nasal Continuous Positive Airway Pressure (NCPAP) therapy in the Intermediate Care Nursery.
- Ensure the availability of a RT 24/7 to provide analysis of blood gases with electrolytes in a timely manner.
- Ensure the availability of a RT at Women’s Centre for post-surgical patients needing non-anticipated prolonged ventilation before extubation and in situations where the patient is waiting for a critical care bed.

**Long-Term Care**

With additional RT resources, efficiencies could be achieved in care delivery at RHC and DLC, as well as improving transition between community, acute, and LTC settings.

A program was launched in April 2003 by the WRHA (LTC Program, Rehab/Geriatrics Program, and Regional RT). The goal of the program was to facilitate the placement of 10 to 12 respiratory clients per year into PCH beds. Historically, respiratory clients requiring long-term oxygen therapy had been placed into respiratory chronic care beds in Winnipeg. It had become apparent that a portion of these clients could have their needs met in a PCH setting if RTs were available to support them.

The program has been successful in the following ways:
- Eliminated the Respiratory Chronic Care waiting list
- Identified 40 clients appropriate for PCH placement
- Provided proactive management of acutely ill residents in PCH’s, minimizing the transfer of these clients to acute care
- Minimized delays in paneling as all clients were screened by the RT
- Eliminated delays in discharge from acute care to PCH due to respiratory issues
- Provided regular maintenance of oxygen equipment
- Developed standards, policies, and guidelines for the evidence-based management of residents with respiratory problems

This effort was achieved with an original staffing of only 0.5 EFTs RT, coordinated by the Regional Manager for LTC Respiratory Therapy. The staffing was based on a predicted 12 residents per year but is inadequate to support the 40 actual respiratory clients scattered over 39 PCH’s and 5,697 beds. To be sustainable, RT staffing for this initiative needs to be increased.
Community Care

There are over 500 clients in Winnipeg on the Provincial Home Oxygen Program and this number grows by five to eight percent per year. There are also an unknown number of clients receiving oxygen privately, outside the provincial program, primarily for dyspnea. These clients are frequent users of Emergency Departments and tend to spend long periods of time as inpatients.

Management of this group has been more reactive than proactive. Medical management falls onto family physicians who may not have extensive expertise in managing this population. Access to specialized assessment/services tends to be focused in the acute care setting and is not readily available in the community.

At this time, RT support in the community is minimal and focused on one specialty program only, Home Ventilatory Assistive Devices Service (HVADS) for adults. There is no dedicated funding for the pediatric HVADS at this time.

Dedicated RT staffing in the community would:

- Reduce inpatient admissions by providing proactive intervention in the community.
- Provide point of care testing in the home and increased compliance with testing. This would reduce the workload on family physicians and acute care RT departments as well as reducing the wait time for tests.
- Ensure clients meet established criteria in order to qualify for home oxygen therapy.
- Provide post discharge follow-up and continuity of care for respiratory clients. This would include assessment, treatment, monitoring, titration of oxygen therapy, education, and reporting back to family physicians and Respirologists.

The RT needs for Long-Term Care and the Community share common themes. With the overwhelming success of the PCH Respiratory Program, it is certain that community-based RTs would also have a positive outcome as demonstrated in the literature and in other regions, e.g. New Brunswick Extramural Hospital.19

Regional Respiratory Therapy Float Pool

Currently each site hires its own casual staff to provide relief for heavy workload, vacation, and sick time. The pool of casual RT staff is relatively small, with RTs rarely electing to work just casual positions. Typically RTs have a full or part time position at one site, and work casual hours at multiple sites, resulting in limited and inconsistent casual staff availability, and dependence on overtime to provide relief coverage. Furthermore, demand for casual staff is variable, making it difficult for individual sites to support permanent relief positions.

Occasionally sites are successful in hiring new graduates for summer relief positions. However, registered therapists must supervise new graduates, therefore, they are of limited benefit to smaller facilities that have single-therapist coverage after hours.

The survey of other health regions across Canada identified that this issue is not unique to Winnipeg. In Calgary and Regina, regional relief pools have been developed to support multiple sites requiring relief staff on an irregular basis. RTs are hired into permanent regional positions and schedules and are rotated on a day-to-day basis to sites that request relief staff coverage.
A similar model in Winnipeg would improve availability of casual staff to sites and reduce reliance on overtime.

Unlike Calgary and Regina, who are functioning under one-employer models, the WRHA would face unique challenges as different collective bargaining agents represent the various disciplines across the sites.

**Service to Rural Areas and Provincial Programs**

Several Regional Health Authorities (RHAs) outside Winnipeg have one or more RTs on staff, while other RHAs have none. Many of these RHAs have patients, clients, and residents with complex respiratory care needs, e.g. provincial home oxygen and long term ventilator clients, requiring clinical and educational support during acute hospital admissions, in Personal Care Homes, and in the community. RHAs that do not have RTs on staff rely on the expertise of Winnipeg-based RTs to provide educational and consultative support. RHAs with RTs on staff may also require support if their RTs have limited exposure to complex respiratory cases.

While changing RT services outside Winnipeg is beyond the scope of this project, the impact of reduced service levels in some RHAs must be considered due to the impact on baseline RT staffing in the WRHA. There may be future opportunities for the RT Clinical Support Program to work with other RHAs that require RT services on a less than full time basis to develop outreach or purchased service arrangements.

**Other Issues Affecting the Delivery and Management of Respiratory Therapy**

- RT professional practice, range of services, and job descriptions are varied across sites.
- Workload measurement and auditing is inconsistent across sites.
- Reporting structure varies from site to site.
- A national trend to increase presence of RTs in the O.R. as “anesthesia therapists” is present across Canada.
- The role of support staff in supporting RT staff with non-clinical tasks is ill defined across Canada.
- The numbers and utilization of RT Clinical Specialists is inconsistent.
- Resources to hire future graduates have been identified as a project enabler and are being pursued by the Regional RT Clinical Support Program, e.g. tuition relief.
- Wages are generally not on par with other jurisdictions making recruitment and retention difficult. Historically, Manitoba has not been successful in recruiting outside the province.
- Respiratory therapists in the region are represented by multiple unions and some are non-union: MAHCP (HSC, SBGH, VGH, MHC, DLC), UFCW (GGH), CUPE (RHC) as well as remaining non-union at SOGH, CH, and WRHA. This complicates planning across sites for issues such as wage differentials, mobility, and classifications.
V. Action Towards Change

The Project Team identified performance targets and deliverables including:
- RT roles more in line with national peers
- RT to ventilated patient ratio to meet or exceed generally accepted national RT standards for patient care and safety
- Improved continuity of care between sectors and populations, e.g. acute and long term care
- Successful recruitment into new and existing positions
- Decreased vacancies
- Decreased rates of staff turnover

A summary of activities completed to achieve project deliverables and performance targets are noted below and detailed in the following pages.

<table>
<thead>
<tr>
<th>Project Deliverable</th>
<th>Activities Completed</th>
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| 1. Standardized practice principles and guidelines across the region including roles, responsibilities, and accountabilities of site-based teams. | • Developed principles and implementation plan  
• Surveyed nine local WRHA sites and Brandon re: RT services; 100% response  
• Surveyed eleven sites outside Manitoba including sites benchmarked by D&T - 100% response  
• Teleconferenced with Regina and Calgary Regional sites for further detail  
• Visited benchmarked sites in London, Ontario  
• Reviewed current literature |
| 2. An agreed upon listing of all respiratory functions to be performed by staff, by program area, matched with the appropriate staff and supporting resources required | • A list of respiratory functions by program area matched with appropriate respiratory staff was prepared and supported by site surveys (Appendix 4)  
• The list was vetted through priority areas including Critical Care and Emergency  
• Received feedback re: duties from five focus groups (Appendix 1) |
| 3. Standardized job classifications and descriptions, i.e. staff RT, Clinical RT Specialist, RT Aide, etc. | • Reviewed job descriptions gathered from regional and local sites  
• Standardization of job descriptions across sites to be completed as part of next steps |
| 4. Models for RT practice reflecting a full scope of practice and accommodating site and program differences | • Developed principles and implementation plan  
• Listed respiratory functions, the foundation for final model of RT practice (Appendix 4)  
• Reviewed results of site visit to inform the model |
| 5. Efficiencies in nursing and physician workload related to respiratory functions performed, particularly in critical care | • Listed respiratory functions, the foundation for final model of RT practice (Appendix 4)  
• Reviewed the results of site visits to inform the model  
• Drafted a multi-year, prioritized implementation plan to support the RT model of practice and to enable workload efficiencies for program teams  
• Developed a plan for implementation |
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<th>Project Deliverable</th>
<th>Activities Completed</th>
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| 6. A short and long term plan for recruitment and retention of respiratory therapy staff | • Drafted a multi-year, prioritized implementation plan to support the RT model of practice and to enable workload efficiencies for program teams  
• Developed a plan for implementation                                               |
VI. Principles for Respiratory Therapy Practice Model

The team identified the following principles for the RT practice model:

1. The model will reflect those duties within the RT Scope of Practice as defined by the Manitoba Association of Registered Respiratory Therapists (MARRT).
2. The model will provide front line professionals’ with direct access to a respiratory therapy manager or director at either a site or regional level.
3. The model will recognize shared clinical respiratory competencies, encourage collective accountability for patient care, and be respectful of other disciplines.
4. The model will be implemented in a manner that ensures sustainability and continuity of clinical presence.
5. Implementation of the model will be a multiyear task, partially dependant on the availability of RT resources and reinvestment opportunities.
6. Site and regional priorities for implementation of RT services will be based on patient acuity and opportunity to improve clinical outcomes.
7. RT Clinical Specialists will be available to support RT Clinical Support Program staff and other healthcare staff. The Clinical Specialists may be site based, regionally based, or a combination of both.
8. The model will reflect the principles of the ABC Allied Health Infrastructure Project.
VII. Structure, Roles, and Responsibilities to Support the Respiratory Therapy Practice Model

The structure needed to support an enhanced model of RT practice will be defined by the Allied Health Infrastructure project.

The proposed organizational structure designates the Regional RT Director accountable for restructuring RT service delivery across the continuum in collaboration with other stakeholders.

Strong site management is required to effectively implement the proposed RT Practice Model.

Site Managers/Charges will have day-to-day responsibility for ensuring site RT needs are met. They will support the staff through the transition to the new model of enhanced scope of practice and provide a link with community and long-term care centres.

Clinical Specialists are required to support RTs and the staff of other programs through the transition to the new model and an enhanced scope of practice, and will be involved in developing standardized clinical practice guidelines.
VIII. Education and Training Plan to Support Implementation

The education and training plan will need to be site and program specific to meet the needs of specific patient populations and to allow for site differences. As part of the project, each WRHA RT Manager completed a survey that identified the duties being performed regularly by RTs at their site. The survey showed that RT duties currently performed at some sites and in some programs areas varied. By comparing performed duties to the proposed model of practice, the gaps and inconsistencies in practice will be identified.

Training plans for each site will be established in consultation with the site RT Clinical Specialists, the RT Regional Director, and RT Managers/Charges.

The RT Regional Director and RT Managers/Charges will review and compare current policy and procedure manuals and select a template for use across the region. Job descriptions will be compared across sites with the assistance of Human Resources. Consistent content will be identified and revisions made as required to describe and support the expanded model of practice.
IX. Model for Respiratory Therapy Practice

Respiratory Therapist competencies, within scope of practice from the Canadian Society of Respiratory Therapists’ Occupational Profile, 2002-2005 are outlined in Appendix 2. This profile is used by the MARRT, within the Registered Respiratory Therapy Act, to define practice in Manitoba. Using this profile, a standardized regional listing of RT duties by program area was developed, included in Appendix 4. This listing outlines the goal for the model for RT duties within scope of practice to be delivered by service area, i.e. Outpatient, Emergency, Wards, and ICUs.

Required linkages between service areas are identified and will be incorporated into operational procedures and job descriptions for all RT staff and site management.

Issues identified will be reconciled or included in the planning of the implementation at the individual sites. Consistent practice standards and guidelines will support the model.

The model has been informed by the London, Ontario site visit, then validated in consultation with the RT Regional Director, RT Managers/Charges, two key stakeholders: the WRHA Emergency Program Teams and Critical Care Program Teams.

Alternate respiratory care providers (e.g. RT Assistant or Aide) have been considered but at this time, their role within the model (and across Canada) is not well defined. The RT Clinical Support Program will review the benefits and limitations of this role.
X. Multi-Year Implementation Plan

A multi-year implementation/reinvestment plan is recommended to support the proposed RT model of practice and facilitate workload efficiencies.

The plan was developed in consideration of:

- Current fiscal environment
- Regional priorities for RT reinvestment
- Available and anticipated resources
- Underlying principles for the RT model (described in Section VI)
- Site survey results

It is important to note this implementation plan reflects the RT needs at this specific point in time and has been planned to demonstrate how the 50.5 EFTs identified by D&T would be prioritized. Re-evaluation of the specifics of the implementation plan would be required if reinvestment is not immediately forthcoming or in the event that the RT Clinical Support Program identifies changing priorities related to region-wide changes.

This plan was prepared in consultation with:

- WRHA RT Regional Director and RT Leaders Group
- Five focus groups of WRHA nurses, physicians, and RTs from all sites, November 2003
- WRHA Critical Care and Emergency Programs
- The ABC Allied Health Infrastructure Project 6.1

The priority areas for RT reinvestment are identified below (not necessarily in order). The implementation priorities will be determined based on available resources and priorities as identified by the RT Clinical Support Program.

- **Critical Care and Emergency**
  - Provide immediate support to facilitate workload efficiencies
  - Enhance patient care and improve throughput of patients
  - Provide asthma and COPD education, treatment, and support

- **Wards**
  - Provide dedicated RT staffing in ICU and Emergency to enable RT ward staff to remain on the ward to provide more consistent delivery of care
  - Enhance respiratory care to patients and support the health care team on wards
  - Enhance discharge planning and decrease LOS

- **Site Clinical Specialists and Site Respiratory Therapy Managers** (as required)
  - Provide infrastructure support to facilitate the transition to the new model and an enhanced scope of practice

- **Regional Respiratory Therapy Manager – Acute and Community Care**
  - Improve integration of services across the health continuum and between sectors for consistency of practice
  - Provide infrastructure support to create efficiencies
• Identify and resolve sector specific issues
• Similar positions in LTC RT and Speech Language Pathology have demonstrated considerable success

✓ Women’s Hospital
  • Provide 24/7 coverage to ensure consistent service and address risk management issues

✓ Unfunded position
  • Provide a source of sustainable funding for an unfunded position at SOGH (RTs were hired to support an expanded program and then funding was not provided)

✓ Regional Respiratory Therapy Float Pool
  • Create an RT Float Pool, potentially reducing reliance on overtime

See Appendix 5 for Specific Recommendations by Fiscal Year.
XI. Recommendations

The Project Team is seeking approval in principle for the recommended changes and requests that funding for this project be given high priority to enable the initiation of a staged implementation.

1. The proposed Allied Health organizational structure, particularly as it relates to the Respiratory Therapy Clinical Support Program, be implemented at all sites within the WRHA as recommended by the Allied Health Infrastructure Project 6.1.²

   **Rationale**
   - Facilitates the implementation of the new model for RT practice
   - Improves the ability to implement efficiencies in the delivery of RT practice across the region
   - Enables the provision of enhanced quality and consistency of care

2. The proposed priorities and multi-year plan for RT reinvestment be accepted. Areas identified at present requiring reinvestment include:
   - Critical Care and Emergency
   - Inpatient Wards
   - Site and Regional Clinical Specialists and Site RT Managers (where required)
   - Regional RT Manager for Acute/Community Care
   - Child/Women’s Health
   - Regional RT Float pool

   **Rationale**
   - Provides immediate returns by improving patient outcomes and decreasing costs related to length of stay and hospital readmissions (Reinvestment in the region was identified by D&T as an immediate 16.5 EFTs - RTs more than 25% lower than peer comparator mid-point, with subsequent 34.0 EFTs for a total of 50.5 EFTs to achieve the 50th percentile of benchmarked sites, recalibrated to 53.4 EFTs based on 2002/03 data)
   - Supports WRHA regional priorities for improved resource utilization and delivery of patient care
   - Aligns with D&T recommendations regarding nursing and RT workload
   - Supports identified RT regional program needs including enhancement of RT services in the community and long term care
   - Lays the groundwork for long-term change to the RT Clinical Support Program, consistent with the Allied Health Infrastructure Project 6.1

3. As resources are made available, implement the proposed RT model of practice to allow RTs to work within full scope of practice.

   **Rationale**
   - Improves patient clinical outcomes
   - Decreases risk management/patient safety issues
   - Provides more efficient use and distribution of resources
   - Improves job and work life satisfaction

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• Improves continuity of care
• Decreases gaps in service
• Facilitates best practice and consistent standards of care
• Facilitates management of overtime/relief issues using tools such as a regional float pool
• Facilitates consistent definitions of clinical and management roles and development of standardized job descriptions
• Facilitates sharing of respiratory clinical specialists and educational resources
XII. Conclusion

The recommendations for implementation of the new model are multiyear and are prioritized by site and program. The plan is based on RT service needs identified through extensive consultation and focus groups and is congruent with D&T immediate and long-term recommendations. The plan lays the groundwork for long-term change to the RT Clinical Support Program as recommended by the Allied Health Infrastructure Project.

At a presentation to the Manitoba Association of Registered Respiratory Therapists in May 2003, and again in May 2004, the clear message from the RTs was that successfully expanding RT duties within scope of practice would require additional RT resources for sustainable, credible change to occur. RTs want to be more proactive and consistently available to work side by side with other members of the team to support the patient and care team.

The message from the focus group participants echoed the opinions of the RTs, i.e. a consistent presence and provision of RT resources is crucial to build trust, improve the quality of work life, and create sustainable workload efficiencies.

The Project Team has presented this new model for RT practice, with supporting infrastructure requirements, and asks that this request be given high priority when funding becomes available to initiate a staged implementation of the plan.

Next Steps

This report will be shared with stakeholders.

The following tasks will be assigned to the Regional Respiratory Therapy Clinical Support Program for completion:

1. Define standardized practice principles and guidelines across the region including roles, responsibilities, and accountabilities of site-based teams.

2. Continue to validate model with WRHA Programs. The Regional Respiratory Therapy Clinical Support Program will consult with sites and programs to ensure investments meet the priority areas at the time of reinvestment and to determine the supports required for a smooth transition to the new model.

3. Standardize job classifications and descriptions for respiratory therapy.

4. Identify site-specific education gaps between current practice and new model. Develop education plans with site RT Clinical Specialists to close the gap, deliver education, and test for competency.

5. Develop implementation plan in consultation with sites, programs, and RT Leaders and roll out model.
Questions regarding this report may be directed to:

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Project Co-Lead  
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Regional RT Director  
Project Lead – Allied Health Infrastructure Project  
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hclark@wrha.mb.ca
XIII. References


XIV. ABC 6.3 Scope of Respiratory Therapy Practice Team Members

**Project Sponsors**

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Sponsor</td>
<td>Réal Cloutier</td>
<td>VP Long Term Care, Chief Allied Health Officer, COO Deer Lodge Centre</td>
</tr>
<tr>
<td>Allied Health Initiative</td>
<td></td>
<td></td>
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<tr>
<td>Initiative Lead</td>
<td>Janet Bjornson</td>
<td>Regional Director, Allied Health and ABC Project Management Office</td>
</tr>
</tbody>
</table>

**Project Team**

<table>
<thead>
<tr>
<th>Role</th>
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<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Lead</td>
<td>Neil Johnston</td>
<td>GGH: Professional Leader, Respiratory Therapy</td>
</tr>
<tr>
<td>Project Lead</td>
<td>Joel Moore</td>
<td>WRHA: Coordinator, Patient Transport</td>
</tr>
<tr>
<td>Team Member</td>
<td>Morna Halparin</td>
<td>VGH: Nurse Educator, Intensive Care Unit</td>
</tr>
<tr>
<td>Team Member</td>
<td>Todd Mortimer</td>
<td>HSC/University of Manitoba: RT Clinical Specialist</td>
</tr>
<tr>
<td>Team Member</td>
<td>Dr. Bojan Paunovic</td>
<td>University of Manitoba: Assistant Professor, Faculty of Medicine, Department of Internal Medicine Section of Critical Care GGH: Medical Director, Intensive Care Unit; Medical Staff</td>
</tr>
<tr>
<td>Team Member</td>
<td>Michaele Rivet</td>
<td>SBGH: Clinical Resource Nurse, Surgical Intensive Care Unit</td>
</tr>
<tr>
<td>Team Member</td>
<td>Tracy Simcoe</td>
<td>HSC: Respiratory Therapist</td>
</tr>
<tr>
<td>Team Member</td>
<td>Anita Underwood</td>
<td>HSC: Manager, RT Services Child Health and Women’s Health Programs</td>
</tr>
<tr>
<td>Team Member</td>
<td>Donald Gibson</td>
<td>Concordia Hospital (CH): Chief Human Resources Officer</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Karen Howell/Susan Gerlach</td>
<td>RT Project Managers</td>
</tr>
<tr>
<td>Consultation</td>
<td>Helen Clark</td>
<td>WRHA: Respiratory Therapy Regional Director</td>
</tr>
</tbody>
</table>
Appendix 1

Summary of Key Themes from Focus Group Sessions
November 2003 (Total N= 31)

1. Respiratory needs of patient population and RT Duties
   - Need to educate health care team about role and training of RTs; understanding is variable dependant on experience and site
   - General surprise at breadth and depth of RT education and training
   - Most recognized important role in education, ventilation, bipap management, codes, and tracheostomy care
   - Recognition that lack of RT support largely due to lack of RT resources

2. Complementary/Shared Duties
   - Very site dependant; abundance of resources in tertiary sites complicates relationship with other team members
   - Relationship may depend on how aggressive RT is, on RT experience; build up of trust
   - Again, recognition that some respiratory tasks done by other members of the team is a reflection of lack of RT resources to respond in timely manner

3. Suggested Changes to Improve RT Role
   - Strong support for increased role in education of staff and inpatients and outpatients; more presence in rounds
   - Need to be active in chronic respiratory care
   - More presence in Emergency, on wards, and on nights; RTs want to be able to be more proactive in care
   - More initiative on units to participate, check on patients regularly; staying with patients during period of adjustments
   - Assign non-clinical duties to Assistant or Aide
   - Uneasy re: “nursing functions” e.g. intravenous, vital signs, hemodynamic monitoring, medication administration, central line management; very concerned of risk of error with overlapping functions at one bedside
   - More tracheostomy care, chest tube care; reintubation
   - Perspective on enhanced duties varies between community and tertiary sites; at tertiary, see duplication to perform “nursing functions”; suggest emphasis on education; more accepting for community sites where fewer resources

4. Barriers for Change/Broadening of Duties Within Scope of Practice
   - Shortage of RTs – will need to demonstrate ability to support new model consistently with adequate staffing
   - Competing education and competency needs at tertiary teaching sites
   - Challenge of obtaining acceptance of new role; need to educate staff re: scope of practice
• If people think they are losing their jobs, some may feel threatened and others may be thinking I’ve done this for years, why is someone else coming in to do this; depends on how RTs communicate and work with people already doing these things

5. Support for Change/Broadening of Duties Within Scope of Practice
- Recognition of opportunity to keep more beds open by enhancing role of RT
- Recognition that enhanced role may increase enrollment in profession
- With shortages in all professions, can’t afford to have underutilized skills
- Already existing models of enhanced scope of practice in the areas of Patient Transport and Pediatrics are working well
### Respiratory Therapist Competencies within Scope of Practice

**Source:** Canadian Society Of Respiratory Therapists, 2000-2005 Occupational Profile

<table>
<thead>
<tr>
<th>Competency</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perform oximetry testing</td>
<td></td>
</tr>
<tr>
<td>2. Invasive and non-invasive monitoring – e.g. hemodynamics, ECG,</td>
<td>NIBP, IBP, endtidal CO₂, transcutaneous, etc.</td>
</tr>
<tr>
<td>3. Bedside spirometry</td>
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<tr>
<td>4. Full pulmonary function testing in lab setting</td>
<td></td>
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<tr>
<td>5. Procure blood samples – capillary, arterial puncture, umbilical cord</td>
<td>blood</td>
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<tr>
<td>6. Insert arterial line</td>
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<tr>
<td>7. Arterial and venous blood gas analysis</td>
<td>a. Arterial and venous blood gas analysis</td>
</tr>
<tr>
<td></td>
<td>b. Electrolyte analysis</td>
</tr>
<tr>
<td>8. Interpret blood analysis results</td>
<td></td>
</tr>
<tr>
<td>9. Provide oxygen therapy</td>
<td></td>
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<tr>
<td>10. Provide humidity therapy</td>
<td></td>
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<tr>
<td>11. Provide aerosol therapy</td>
<td></td>
</tr>
<tr>
<td>12. Perform suction therapy</td>
<td></td>
</tr>
<tr>
<td>13. Maintain nasal or oral airway</td>
<td>a. Maintain nasal or oral airway</td>
</tr>
<tr>
<td></td>
<td>b. Nasopharyngeal tube</td>
</tr>
<tr>
<td>14. Perform manual ventilation</td>
<td></td>
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<tr>
<td>15. Perform intubation</td>
<td></td>
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<tr>
<td>16. Maintain endotracheal tubes</td>
<td></td>
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<tr>
<td>17. Assist with tracheostomy</td>
<td></td>
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<tr>
<td>18. Maintain tracheostomy tubes</td>
<td></td>
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<tr>
<td>19. Initiate mechanical ventilation</td>
<td></td>
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<tr>
<td>20. Mechanical ventilation graphics analysis and interpretation</td>
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<td></td>
<td>b. High Frequency</td>
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<tr>
<td>22. Weaning mechanical ventilator</td>
<td></td>
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<tr>
<td>23. Weaning parameters</td>
<td></td>
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<tr>
<td>24. Perform extubation</td>
<td></td>
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<tr>
<td>25. Perform decannulation</td>
<td></td>
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<tr>
<td>26. Provide non-invasive positive pressure ventilatory support</td>
<td></td>
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<tr>
<td>27. Administer heliox</td>
<td></td>
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<tr>
<td>28. Administer nitric oxide</td>
<td></td>
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<tr>
<td>29. Administer surfactant replacement therapy</td>
<td></td>
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<tr>
<td>30. Manage technical demands associated with transport and independent</td>
<td>travel - in house and external</td>
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<tr>
<td>31. Manage clinical demands associated with transport - in house and</td>
<td>external</td>
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<tr>
<td>32. Assist in bronchoscopy procedures</td>
<td></td>
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<tr>
<td>33. Chest tubes – set up/maintain closed chest drainage systems</td>
<td></td>
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<tr>
<td>34. Provide consult service e.g. chest assessment</td>
<td></td>
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<tr>
<td>35. Patient/family education – in and outpatient</td>
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<tr>
<td>36. Supervise students and staff</td>
<td></td>
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<tr>
<td>37. Other technical duties: e.g. maintaining medical gases, outlet</td>
<td>repair and maintain, fixing equipment such as flow meters, suction regulators, ventilators,</td>
</tr>
<tr>
<td>and maintain, fixing equipment such as flow meters, suction</td>
<td>blood gas machines</td>
</tr>
<tr>
<td>regulators, ventilators, blood gas machines</td>
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<tr>
<td>38. High risk delivery attendance</td>
<td></td>
</tr>
<tr>
<td>39. Code 25 attendance (i.e. med. Emergency; non-arrest)</td>
<td></td>
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<tr>
<td>40. Code Blue attendance</td>
<td></td>
</tr>
<tr>
<td>41. Official Respiratory Therapy Consult</td>
<td></td>
</tr>
<tr>
<td>42. History and physical assessment, including interpretation of lab</td>
<td>and radiological data</td>
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<tr>
<td>and radiological data</td>
<td></td>
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<tr>
<td>43. Cardio-respiratory Assessment – full; modified</td>
<td></td>
</tr>
<tr>
<td>44. I.V. starts and maintenance</td>
<td></td>
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<tr>
<td>45. Administer meds– inhaled, IV, IM, ETT, subcutaneous, topical</td>
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<td>46. Central line insertion</td>
<td></td>
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<td>47. Thermal regulation</td>
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<td>48. Research</td>
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<tr>
<td>49. Hyperbaric therapy</td>
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## Appendix 3

### Sites Indicating Duties Performed by Respiratory Therapist

<table>
<thead>
<tr>
<th>Survey Responses to Respiratory Duties Within Scope of Practice</th>
<th># &quot;In Scope&quot;</th>
<th>Survey Responses</th>
<th>% &quot;In Scope&quot;</th>
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<tbody>
<tr>
<td>1. Perform oximetry testing</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>2. Invasive &amp; Non-invasive monitoring – endtidal CO2, transcutaneous</td>
<td>18</td>
<td>21</td>
<td>86%</td>
</tr>
<tr>
<td>3. Bedside Spirometry</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>4. Provide oxygen therapy</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>5. Procure blood samples – capillary, arterial puncture, umbilical cord blood, arterial line</td>
<td>19</td>
<td>21</td>
<td>90%</td>
</tr>
<tr>
<td>6. Provide humidity therapy</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>7. Provide aerosol therapy</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>8. Provide suction therapy</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>9. Provide aerosol therapy</td>
<td>21</td>
<td>21</td>
<td>100%</td>
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<tr>
<td>10. Perform manual ventilation</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>11. Provide aerosol therapy</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>12. Perform suction therapy</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>13. a. Maintain nasal or oral airway</td>
<td>20</td>
<td>21</td>
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<tr>
<td>15. Perform intubation</td>
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<td>16. Maintain endotracheal tubes</td>
<td>19</td>
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<tr>
<td>17. Maintain tracheostomy tubes</td>
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<td>19. Initiate mechanical ventilation</td>
<td>18</td>
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<td>20. Mechanical ventilation graphics analysis and interpretation</td>
<td>18</td>
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<tr>
<td>21. Vent management – site protocols / physician directed</td>
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<td>22. Weaning mechanical vent – RT directed / physician directed</td>
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<td>23. Weaning parameters</td>
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<tr>
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<td>25. Patient/family education – in and outpatient</td>
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<td>100%</td>
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<td>27. Administer heliox</td>
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<td>86%</td>
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<tr>
<td>28. Provide consult service, e.g. chest assessment</td>
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<td>21</td>
<td>90%</td>
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<tr>
<td>29. Provide consult service, e.g. chest assessment</td>
<td>19</td>
<td>21</td>
<td>90%</td>
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<td>30. Manage technical demands - transport &amp; independent travel</td>
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<tr>
<td>31. Manage clinical demands - transport-in-house and external</td>
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<td>*46. Administer med – inhaled, IV, IM, ETT, subcutaneous, topical</td>
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<td>19</td>
<td>21</td>
<td>90%</td>
</tr>
<tr>
<td>35. Code Blue attendance</td>
<td>18</td>
<td>21</td>
<td>86%</td>
</tr>
<tr>
<td>36. Supervise students and staff</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>37. Interpret blood analysis results</td>
<td>20</td>
<td>21</td>
<td>95%</td>
</tr>
<tr>
<td>38. Interpret blood analysis results</td>
<td>20</td>
<td>21</td>
<td>95%</td>
</tr>
<tr>
<td>39. Code “25” attendance (i.e. medical emergency – non-arrest)</td>
<td>18</td>
<td>21</td>
<td>86%</td>
</tr>
<tr>
<td>40. Code Blue attendance</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>41. Interpret blood analysis results</td>
<td>20</td>
<td>21</td>
<td>95%</td>
</tr>
<tr>
<td>42. Interpret blood analysis results</td>
<td>20</td>
<td>21</td>
<td>95%</td>
</tr>
<tr>
<td>43. Interpret blood analysis results</td>
<td>20</td>
<td>21</td>
<td>95%</td>
</tr>
<tr>
<td>44. Interpret blood analysis results</td>
<td>20</td>
<td>21</td>
<td>95%</td>
</tr>
<tr>
<td>45. Interpret blood analysis results</td>
<td>20</td>
<td>21</td>
<td>95%</td>
</tr>
<tr>
<td>46. Administer med – inhaled, IV, IM, ETT, subcutaneous, topical</td>
<td>19</td>
<td>20</td>
<td>95%</td>
</tr>
</tbody>
</table>
### Survey Responses to Respiratory Duties Within Scope of Practice

<table>
<thead>
<tr>
<th>Duty Description</th>
<th># &quot;In Scope&quot;</th>
<th>Survey Responses</th>
<th>% &quot;In Scope&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Assist with tracheostomy</td>
<td>15</td>
<td>21</td>
<td>71%</td>
</tr>
<tr>
<td>4. Full pulmonary function testing in lab setting</td>
<td>14</td>
<td>21</td>
<td>67%</td>
</tr>
<tr>
<td>*43. Cardio-respiratory assessment – full; modified</td>
<td>13</td>
<td>20</td>
<td>65%</td>
</tr>
<tr>
<td>6. Insert arterial line</td>
<td>13</td>
<td>21</td>
<td>62%</td>
</tr>
<tr>
<td>28. Administer nitric oxide</td>
<td>13</td>
<td>21</td>
<td>62%</td>
</tr>
<tr>
<td>37. Technical duties: e.g. maintaining medical gases, outlet repair/maintain, fixing equipment e.g. flowmeters, suction regulators, ventilators, blood gas machines</td>
<td>13</td>
<td>21</td>
<td>62%</td>
</tr>
<tr>
<td>*42. History and physical assessment re: respiratory function, including interpretation of lab and radiological data</td>
<td>12</td>
<td>20</td>
<td>60%</td>
</tr>
<tr>
<td>21. Vent management – site protocols / physician directed</td>
<td>12</td>
<td>21</td>
<td>57%</td>
</tr>
<tr>
<td>b. High Frequency – RT directed / physician directed</td>
<td>12</td>
<td>21</td>
<td>57%</td>
</tr>
<tr>
<td>38. High risk delivery attendance</td>
<td>12</td>
<td>21</td>
<td>57%</td>
</tr>
<tr>
<td>*49. Research</td>
<td>11</td>
<td>20</td>
<td>55%</td>
</tr>
<tr>
<td>7b. Electrolyte analysis</td>
<td>11</td>
<td>21</td>
<td>52%</td>
</tr>
<tr>
<td>25. Perform decannulation</td>
<td>11</td>
<td>21</td>
<td>52%</td>
</tr>
<tr>
<td>33. Chest tubes – set up / maintain closed chest drainage systems</td>
<td>11</td>
<td>21</td>
<td>52%</td>
</tr>
<tr>
<td>*41. Official Respiratory Therapy Consult</td>
<td>10</td>
<td>20</td>
<td>50%</td>
</tr>
<tr>
<td>*45. IV starts and maintenance</td>
<td>4</td>
<td>20</td>
<td>20%</td>
</tr>
<tr>
<td>*48. Thermal regulation</td>
<td>4</td>
<td>20</td>
<td>20%</td>
</tr>
<tr>
<td>*44. Hemodynamic monitoring</td>
<td>2</td>
<td>20</td>
<td>10%</td>
</tr>
<tr>
<td>*47. Central line insertion</td>
<td>1</td>
<td>20</td>
<td>5%</td>
</tr>
<tr>
<td>*50. Hyperbaric therapy</td>
<td>0</td>
<td>20</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Note: These duties were not included on the survey administered to the sites.

### Other duties NOT on the list provided, but identified by respondents as being within scope and performed by front line RRTs included:
- EKG exams
- RTs work in Cardiac Catheritization labs as unregistered CardioVascular Technicians until they challenge exams; do hemodynamic monitoring, assist with all procedures, administer meds, etc.
- Extracorporeal Membrane Oxygenation (ECMO)
- Attend high risk deliveries for resuscitation and/or meconium aspiration
- Sleep Laboratory

### Manitoba Sites Contacted
- Deer Lodge Centre
- Riverview Health Centre
- Concordia Hospital
- Seven Oaks General Hospital
- Victoria General Hospital
- Grace General Hospital
- Brandon Regional Health Centre
- St. Boniface General Hospital
- Health Sciences Centre, Adult RT Program

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• Health Sciences Centre, Pediatric RT Program
• Misericordia Health Centre

National Sites Contacted
• Calgary Health Region – Foothills, Peter Lougheed, Rockyview Hospitals
• University of Alberta Hospital
• Sunnybrook and Women’s Health Sciences Centre
• Regina Qu’Appelle Health Region
• Scarborough Grace
• Credit Valley Hospital, Mississauga
• Royal University Hospital, Saskatoon, SK
• BC Children’s and Women's Health Centre of British Columbia
• Hospital for Sick Children, Toronto
• St. Joseph’s Health Sciences Centre, Toronto
## Appendix 4

### Respiratory Therapy Duties Within Scope of Practice by Program Area

<table>
<thead>
<tr>
<th>Area/Task</th>
<th>Outpatient</th>
<th>Emergency</th>
<th>Wards</th>
<th>ICU</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Assessment</strong></td>
<td>Physical Assessment</td>
<td>Physical Assessment</td>
<td>Physical Assessment</td>
<td>Physical Assessment</td>
<td>- SOGH – night coverage is not funded except for call</td>
</tr>
<tr>
<td><strong>Pulmonary Function Tests/Spirometry</strong></td>
<td>Pulmonary function test/spirometry including research</td>
<td>Spirometry</td>
<td>Spirometry</td>
<td>Spirometry</td>
<td>- Need to link out-patient to Community Access Centres</td>
</tr>
</tbody>
</table>
| **Blood Gases**                | Blood gas procurement including analysis, interpretation from any site, i.e. radial, brachial, femoral | Blood gas procurement including analysis, interpretation from any site, i.e. radial, brachial, femoral | Blood gas procurement including analysis, interpretation from any site, i.e. radial, brachial, femoral | Blood gas procurement including analysis, interpretation from any site, i.e. radial, brachial, femoral | - Blood gas puncture should be done by RTs  
- Ensure training in radial, brachial, femoral  
- Blood gas machine in Emergency |
| **Asthma Care**                | Asthma Education; Asthma Assessment, i.e. physical, history, spirometry, other tests as required; action plan; Asthma Teaching; Consultation with other professions including family physician for med. changes and additions | Asthma care map; referral to outpatient; Asthma Assessment and treatment | Asthma care map, education, and referral to outpatient |                          | - Link Asthma in Outpatients, Emergency, Wards  
- Link with WRHA Asthma Initiative  
- Currently at SOGH and CH  
- SOGH model for asthma care map for other sites  
- SOGH RT led  
- Asthma educators- certification preferred |
| **Bronchoprovocation Test**    | Bronchoprovocation test                |                                     |                                |                          | - Link COPD in Out-patients, Emergency, Wards  
- Link with existing programs                                           |
<p>| <strong>Chronic Obstructive Pulmonary Disease (COPD)</strong> | COPD Rehab Program | COPD education (basic) and referral to outpatient | COPD education (basic) |                          |                                                                          |</p>
<table>
<thead>
<tr>
<th>Area/Task</th>
<th>Outpatient</th>
<th>Emergency</th>
<th>Wards</th>
<th>ICU</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oximetry</td>
<td>Oximetry, including walking oximetry</td>
<td>Oximetry therapy start, stop/titration</td>
<td>Oximetry therapy start, stop/titration</td>
<td>Oximetry therapy start, stop/titration</td>
<td></td>
</tr>
<tr>
<td>Humidity Therapy</td>
<td></td>
<td>Humidity Therapy</td>
<td>Humidity Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metabolic Testing</td>
<td>Metabolic Testing</td>
<td></td>
<td></td>
<td></td>
<td>Metabolic Studies shared with dietitian; can reduce ventilation time</td>
</tr>
<tr>
<td>Aerosol Therapy</td>
<td>Specialized aerosols e.g. pentamadine</td>
<td>Aerosol therapy start; metered dose inhaler (MDI)/puffer switchover and teaching as part of Asthma Care Map; spacer device teaching</td>
<td>Aerosol therapy start; MDI switchover and teaching; spacer device teaching</td>
<td>Aerosol therapy</td>
<td>Aerosols shared with nurses; RT could start then RT assistant. continue with routine therapy</td>
</tr>
<tr>
<td>Tracheostomy Care</td>
<td>Trach care, change, and assessment</td>
<td>Trach care, change, and assessment</td>
<td>Trach care, change, and assessment</td>
<td></td>
<td>Need to link to Community Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>More RT resources to trach care could move patients out of ICU earlier</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>Resuscitation</td>
<td>Resuscitation</td>
<td>Resuscitation</td>
<td></td>
<td>All RTs should have ACLS training; to be able to offer suggestions as member of code blue team</td>
</tr>
<tr>
<td>Airway Management</td>
<td></td>
<td>Airway (A/W) mgmt including suction, intubation</td>
<td>A/W mgmt including suction, intubation</td>
<td>A/W mgmt including; suction, intubation, extubation, and repositioning tube</td>
<td>Emergency physicians should be free from hands on work to be team leader and manage code; RT to direct A/W mgmt.</td>
</tr>
<tr>
<td>Ventilator Management</td>
<td>Home Ventilatory Assistive Devices Service (HVADS)</td>
<td>Vent management including invasive and non-invasive positive pressure ventilation (NPPV)</td>
<td>Vent management including NPPV (nocturnal; new CPAP and Bilevel start or change)</td>
<td>Vent management including invasive and (NPPV)</td>
<td>Link NPPV to HVADS; NPPV protocols need to be standardized; RT driven vent protocols needed; facilitates consistency in practice; reduces vent time; 24 hr monitoring req’d but ICU bed not avail. and too heavy for ward; Consider RT call back to monitor which could keep pt. out of ICU bed; Provision for call back for NPPV not in all RT union agreements; SOGH – physician orders at multidisciplinary rounds</td>
</tr>
<tr>
<td>Area/Task</td>
<td>Outpatient</td>
<td>Emergency</td>
<td>Wards</td>
<td>ICU</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------</td>
<td>-----------</td>
<td>-------</td>
<td>-----</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Transport</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pre and post transport evaluation/mgmt.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre and post transport evaluation/mgmt.</td>
<td></td>
<td>Pre and post transport evaluation/mgmt.</td>
<td>Pre and post transport evaluation/mgmt.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transport (intra and interfacility) when transport team not avail. or if heavy care pt.</td>
<td></td>
<td>Transport (intra and interfacility) when transport team not available or if heavy care pt.</td>
<td>• Based on Calgary model where evaluation prior to transport and upon return</td>
</tr>
<tr>
<td>Respiratory Assessment</td>
<td>Assessment</td>
<td>Assessment</td>
<td>Assessment</td>
<td>Assessment</td>
<td></td>
</tr>
<tr>
<td>Gas Therapy</td>
<td></td>
<td>Medical gas therapy e.g. heliox/N₂O</td>
<td></td>
<td></td>
<td>Specialized gas therapy</td>
</tr>
<tr>
<td>Sleep Studies</td>
<td></td>
<td>Overnight (O/N) oximetry (basic sleep studies)</td>
<td></td>
<td></td>
<td>• Sleep studies on wards could tie in to HVADS and Sleep Lab, i.e. assess if need full Sleep Lab assessment/HVADS</td>
</tr>
<tr>
<td>Arterial Line</td>
<td></td>
<td>Arterial line insertion any site, i.e. radial, brachial, femoral</td>
<td></td>
<td>Arterial line insertion any site, i.e. radial, brachial, femoral</td>
<td>• RTs rotate through areas to maintain competency</td>
</tr>
<tr>
<td>Intravenous Line</td>
<td>IV insertion – backup to nursing as needed</td>
<td>IV insertion – backup to nursing as needed</td>
<td>IV insertion – backup to nursing as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Oxygen Program</td>
<td>Home Oxygen Program</td>
<td>In Observation - Short Term O₂ Program (STOP)</td>
<td>Short Term O₂ Program (STOP)</td>
<td></td>
<td>• STOP link to Home O₂ program</td>
</tr>
<tr>
<td>Rounds</td>
<td></td>
<td>Rounds - active participation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td></td>
<td>Non-invasive monitoring e.g. oximetry, end tidal CO₂</td>
<td></td>
<td>Hemodynamics monitoring capabilities</td>
<td></td>
</tr>
</tbody>
</table>

**Student supervision, mentoring, preceptoring**

**Resource to other health care professionals**
Other Practice Areas not reviewed as part of this project.
Will be reviewed under Allied Health Infrastructure Project 6.1 include:

- Anesthesia
- Sleep Lab
- On call RT coverage for all areas
- Break relief
- Central lines
- Transport, etc.
### Appendix 5

#### Specific Recommendations by Fiscal Year
(Contingent on timing of available resources and priorities of the RT Clinical Support Program)

<table>
<thead>
<tr>
<th>Year 1</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Area</td>
<td>EFT</td>
<td>Effect</td>
<td>Rationale</td>
</tr>
<tr>
<td>HSC</td>
<td>Emergency</td>
<td>5.0</td>
<td>1 position 24/7</td>
<td>Priority of Emergency is addressed; RTs available to patient care team to focus on management of respiratory therapy patients, e.g. focus groups identified the need for asthma/patient education support</td>
</tr>
<tr>
<td>GGH</td>
<td>Emergency</td>
<td>2.5</td>
<td>Improves 1 position from 12/7 to 24/7</td>
<td>RT resources to support wards to enable RTs in ICU and Emergency to remain focused in those areas rather than attempting to meet competing demands for services</td>
</tr>
<tr>
<td>GGH</td>
<td>Wards</td>
<td>2.0</td>
<td>Shared amongst wards, to allow coverage to Emergency and ICUs</td>
<td>GGH RT Services supported by Senior Management to trial a full implementation of the model. RT Services already making changes to enable RTs to do clinical work, i.e. currently piloting Unit Assistants taking over portable O₂ tank changes; stores area taking over supplying all RT consumables to units</td>
</tr>
<tr>
<td>HSC</td>
<td>Critical Care</td>
<td>1.0</td>
<td>Clinical RT Specialist</td>
<td>Support implementation of model, staff education, and patient care in all Critical Care Units and Emergency; Facilitate increased regional role for existing Clinical Specialist responsible for LTV</td>
</tr>
<tr>
<td>VGH</td>
<td>Entire site</td>
<td>1.0</td>
<td>1.0 RT Manager at each site</td>
<td>Professional practice RT manager at sites, where lacking, to lay ground work to support changes to scope of practice and principles for RT model; Supports the Allied Health Infrastructure model</td>
</tr>
<tr>
<td>SBGH</td>
<td>Entire site</td>
<td>1.0</td>
<td>1.0 RT Manager at each site</td>
<td>Professional practice RT manager at sites, where lacking, to lay ground work to support changes to scope of practice and principles for RT model; Supports the Allied Health Infrastructure model</td>
</tr>
<tr>
<td>HSC</td>
<td>Women’s Critical Care</td>
<td>1.6</td>
<td>Brings 1 position to 24/7</td>
<td>Risk management issue and support as shared coverage between Women’s and Children’s, especially nights, has sometimes delayed response to Women’s because of competing needs; included in D&amp;T calculations (<a href="#">see further supporting comments, Appendix 6</a>)</td>
</tr>
<tr>
<td>CH</td>
<td>Entire site</td>
<td>1.0</td>
<td>Clinical RT Specialist</td>
<td>Addresses Clinical RT Specialist required at CH to support implementation of model, staff education, and patient care management in all areas</td>
</tr>
<tr>
<td>Regional</td>
<td>1.0</td>
<td>Acute Care/Community Manager</td>
<td>Regional Acute Care RT Manager to improve linkages with sites and community; focus on quality, standards, risk management, etc.</td>
<td></td>
</tr>
<tr>
<td>Regional</td>
<td>1.0</td>
<td>Long Term Care Clinical Specialist</td>
<td>Regional Clinical RT Specialist in Long Term Care to provide efficiencies/linkages with all sites, support staff continuity of care, education and patient care management at PCH and LTC facilities</td>
<td></td>
</tr>
</tbody>
</table>

| Total Year 1 | 17.1 |
### Scope of Respiratory Therapy

#### Year 2
- Continued priority for support to critical care areas
- Provides for regional linkages and efficiencies as model rolls out

<table>
<thead>
<tr>
<th>Site</th>
<th>Area</th>
<th>EFT</th>
<th>Effect</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSC</td>
<td>Critical Care</td>
<td>5.0</td>
<td>1 position each 24/7 for MICU and SICU</td>
<td>• Priority of Critical Care further supported</td>
</tr>
<tr>
<td>VGH</td>
<td>Critical Care and wards shared</td>
<td>2.5</td>
<td>• Priority of Critical Care further supported; RT resources to support wards and allow RTs in Emergency/ICUs to improve presence and continuity of care in units</td>
<td></td>
</tr>
<tr>
<td>SOGH</td>
<td></td>
<td>1.5</td>
<td></td>
<td>• Addresses deficit at SOGH (included by D&amp;T as unfunded); RTs hired to support Clinical Support Program expansion and 24 hour in-house coverage, then funding not provided</td>
</tr>
<tr>
<td>SBGH</td>
<td></td>
<td></td>
<td>Expand site based Technical RT Specialist’s duties to include a regional role</td>
<td>• Regional responsibilities to RT Technical Specialist sited at SBGH to provide efficiencies/linkages with all sites re: trial/evaluation and education re: emerging technologies, capital acquisitions, etc.</td>
</tr>
</tbody>
</table>

**Total Year 2** 14.0

#### Year 3
- Continued priority for support to critical care areas
- Provides regional resources for linkages and continuity of care as model rolls out

<table>
<thead>
<tr>
<th>Site</th>
<th>Area</th>
<th>EFT</th>
<th>Effect</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBGH</td>
<td>Critical Care</td>
<td>5.0</td>
<td>1 position each 24/7 for MICU and SICU</td>
<td>• Priority of Critical Care further supported; time allowed for RT Manager to implement changes to SBGH RT Clinical Support Program as well as changes to Cardiac Sciences Program at SBGH</td>
</tr>
<tr>
<td>Regional Float Pool</td>
<td></td>
<td>1.6</td>
<td></td>
<td>• Provides opportunity to trial a regional RT Float pool (Regina Regional currently uses float pool for 3 sites with 3 RT EFTs)</td>
</tr>
<tr>
<td>Regional</td>
<td>Home Care &amp; Community</td>
<td>1.0</td>
<td>Clinical Specialist</td>
<td>• Regional Clinical RT Specialist in Home Care and Community to provide continuity of care, efficiencies and clinical expertise for all sites and Access Centres and support complex respiratory clients in the community</td>
</tr>
</tbody>
</table>

**Total Year 3** 12.6

#### Year 4
- Support RT presence and continuity of care on nights with new model

<table>
<thead>
<tr>
<th>Site</th>
<th>Area</th>
<th>EFT</th>
<th>Effect</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSC</td>
<td>Wards Shared</td>
<td>3.4</td>
<td>Night coverage</td>
<td>• Addition of remaining RT resources to be shared by wards to support the wards on nights and allow RTs in Emergency and ICUs to remain on those units; need night coverage as RT ward coverage only 16 hours</td>
</tr>
<tr>
<td>SBGH</td>
<td></td>
<td>3.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Year 4** 6.8

**Total 4 Year Rollout 50.5 EFT**