REVIEW OF NON-PHYSICIAN PRESCRIBING and ADMINISTRATION of DRUGS
Under the REGULATED HEALTH PROFESSIONS ACT

Questionnaire for Health Professions

PROFESSION INFORMATION
1. Name of the health regulatory college, professional association or organization responding to this questionnaire. If this response is from more than one organization, please list the names of the organizations.
   College of Respiratory Therapists of Ontario

2. Address/website.
   180 Dundas Street West, Suite 2103
   Toronto, On M5G 1Z8
   www.crto.ca

3. Telephone and fax numbers.
   Telephone 416-591-7800; facsimile 416-591-7890

4. Contact person (including day telephone numbers and e-mail address).
   Christine Robinson, Registrar – 416-591-7800 x 21; robinson@crto.on.ca

5. List other professions, organizations or individuals who could provide relevant information.
   Please provide contact names, addresses and contact numbers where possible.
   Respiratory Therapy Society of Ontario (provincial professional association)
   6519-B Mississauga Road
   Mississauga, ON
   L5N 1A6
   Telephone 905-567-0020, facsimile 905-567-7191
   Contact: Noreen Chan, President (nchan@tegh.on.ca)

FOR PROFESSIONAL ASSOCIATIONS
6. Names and positions of the senior directors and officers.

7. Length of time the association has existed as a representative organization for the profession.

8. List name(s) of any provincial, national or international association(s) for the profession with which your association is affiliated or who may have an interest in this application. Please provide contact names, addresses, contact numbers and e-mail address where possible.

CURRENT AUTHORIZED ACTS AND REGULATIONS
9. Do current authorized acts and regulations reflect best practices for the prescribing or administration of drugs in the course of practice of members of your profession?

   Respiratory Therapists are authorized via the Respiratory Therapy Act (RTA)\(^1\) section 4 to:

---
\(^1\) Respiratory Therapy Act, 1991.
In the course of engaging in the practice of respiratory therapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

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

Regarding authorized act #4, specific medications to be administered are not defined in a regulation. In determining which medications Members are permitted to administer a member would rely upon:

1. Whether the administration falls within the scope of practice as outlined in the RTA.
2. Whether the Member is legally authorized to administer the substance/drug; i.e., the Member has received the appropriate order or delegation.
3. Whether the Member has the competence to administer the substance/drug; i.e., he/she has the knowledge, skill and judgment.
4. Whether it is in the best interest of the patient.

Concerning the requirement for an order, section 5(1) of the RTA states:

A member shall not perform a procedure under the authority of paragraph 1, 2 or 4 of section 4 unless the procedure is ordered by,

(a) a member of the College of Physicians and Surgeons of Ontario, the College of Midwives of Ontario or the Royal College of Dental Surgeons of Ontario;

(b) a member of the College of Nurses of Ontario who holds an extended certificate of registration under the Nursing Act, 1991; or

(c) a member of a health profession that is prescribed by regulation.

Currently, Respiratory Therapists (RT) are not authorized to administer medication without an order, or to prescribe medication. With the exception of suctioning, RTs are unable to initiate any of the other authorized acts in the absence of a valid order. In addition, depending on the interpretation, the Hospital Management Regulation 965 under the Public Hospitals Act would appear to require an order for all procedures/ treatment performed in a hospital setting. Therefore, merely adding an exception for the need for an order for the administration of a drug or substance under the RTA may not be sufficient to permit our Members to access this act within a hospital setting.

One of the limitations of the current legislation is the authorization for Respiratory Therapists to initiate and titrate oxygen independently, i.e., in the absence of an order from one of the healthcare professionals (HCP) listed above. It is our opinion that this restricts our Members’ ability to respond to their patient’s immediate needs and creates an unnecessary barrier to optional patient care.
PROPOSED CHANGES TO AUTHORIZED ACTS AND REGULATIONS

10. Please describe in detail any proposed changes to current authorized acts and regulations that would reflect best practices for:

   a) prescribing of drugs by members of your profession,

   The CRTO is requesting that Respiratory Therapists be granted the ability to prescribe order oxygen. Oxygen is the drug/ substance that RTs utilize most often in their practice and RTs receive extensive training in oxygen therapy. The 8th controlled act under the RHPA 27 (2) is:

   *Prescribing, dispensing, selling or compounding a drug as defined in the Drug and Pharmacies Act, or supervising the part of the pharmacy where such drugs are kept.*

   Therefore, it would necessary to add to the RTA a modified portion of the 8th controlled act to permit Respiratory Therapists to prescribe oxygen.

   b) administration of drugs by members of your profession.

   RTs already have authority, through authorized act # 4 in the RTA to administer a substance by injection or inhalation. Currently, there is some question as to whether oxygen is considered to be a drug under this act and this matter will have to be addressed in consideration of this request. Apart from that, there are no changes that are needed to this aspect of the RTs practice at present.

11. Why are these changes necessary?

   In many situations it is the Respiratory Therapist that is called upon to assess the need for, select the delivery method of, and apply the oxygen for the client. Within a hospital it is the RT who is considered to be an authority and one of the most knowledgeable health care professionals regarding oxygen therapy. Also, the evaluation for the patient who requires home oxygen is most often performed by Respiratory Therapists. RTs are the health care providers (HCP) most often employed by home care companies to go into patient's homes and routinely reassess the client's oxygen needs. As it now stands, information concerning the patient's oxygen requirements must be relayed to the physician for the necessary order/prescription, creating a delay in the patient receiving necessary oxygen.

   It should be noted that although a physician's order/prescription is currently required for oxygen, it is routinely the RT, and not the physician, that assesses and determines the need for oxygen therapy. As such, we see this as an unnecessary step causing undue delay in the hospital settings. Patients on oxygen awaiting discharge into the community may also experience significant delays as the RT, who does the assessment for the oxygen, must wait for a physician's order before making arrangements with the home care company. In addition to the distress this causes the patient, the delay also impacts on length of stay and disrupts the discharge planning process.

   What regulatory or clinical practice purposes would be served by such changes? How would they advance patient care and patient safety?

   As mentioned above, providing the regulatory authority to the RT to prescribe/ order oxygen would eliminate the necessity of a physician's order and thus improve the efficiency with which patient's oxygen needs are met. In the hospital setting there is no HCP, beyond
physicians, who can initiate or titrate a client's oxygen without an order. This can create an unnecessary delay in implementing care, which can have serious consequences to the patient. Hypoxemia is a condition in which there is an inadequate supply of oxygen in arterial blood which can lead to multiple organ systems damage especially in those systems with high oxygen utilization rates such as the central nervous system. A patient’s oxygen requirements can be monitored non-invasively with the use of oxygen saturation monitors. However, as it stands now, even if the RT was to note a critical desaturation (oxygen saturation below optimal range) they would have to wait until a valid order was obtain from a physician before initiating oxygen therapy.

12. Are the proposed changes considered part of current routine practice of the profession, and authorized to members by medical directives, orders or delegation?

Yes, currently RTs are receiving the authority to administer oxygen administration via direct orders or medical directives.

Please describe. If authorized by medical directives, orders or delegation, is this approach inadequate or insufficient? Please explain.

Yes, in our view, the requirement for an order or delegation to administer oxygen creates a barrier to optimum and timely care. The need to have a pre-existing order for oxygen setting or saturation is often overlooked in the clinical setting. Therefore, should the client’s condition change and their oxygen requirements increase, there is often no order to permit the initiation and/or titration of oxygen. This may result at best in significant patient distress and at worst, an acute deterioration in their condition. Conversely, patients who no longer require oxygen may remain on inappropriate levels of oxygen for significant periods of time. Unnecessary use of oxygen can lead a patient to think that they are more sick than they actually are. It severely limits their mobility and rehabilitation and this scenario promotes a longer than required length of stay. Even if there is a standing order or medical directive, it is sometimes inappropriate for all patient populations to receive commonly prescribed oxygen levels. (e.g., elderly patients, clients who have a predisposition to CO2 narcosis, which is an abnormal sensitivity to supplemental oxygen).

13. Would the proposed changes result in an enhanced or changed scope of practice for the profession?

There would be no change in the core activity of oxygen administration by Respiratory Therapists, however, the prescribing/ordering of oxygen would be a new activity for RTs.

14. Please describe in detail any changes or additions that would be required to the controlled acts that are now authorized to the profession and what, if any, limitations or conditions should be attached to the authorized act.

It would necessary to add to the RTA a modified portion of the 8th controlled act (under the RHPA) to permit Respiratory Therapists to prescribe oxygen.

We are proposing that the ordering/prescribing of a drug/substance be limited to oxygen only. There is currently no limitation of which we are aware to prescribing oxygen to patients in a hospital setting. However, at this time, in order to receive funding, patients on home
oxygen require an order by a physician with an OHIP billing number. If Respiratory Therapists are to be permitted to prescribe oxygen for patients in the community a change in the current requirements under the Assistive Devices Program would be required.

15. (a) Has the profession submitted a request to the Ministry of Health and Long-Term Care for changes or additions to the list of drugs that are included in the regulation under the profession-specific act? If yes, please attach copies of the submissions, and indicate when the request was made. No

(b) Are there additions or changes, since the submission was made, that HPRAC should now consider? Please describe in detail. N/A

(c) If a formal submission has not been made at this time, what are the exact changes you now propose to current legislation and regulations? N/A

RISK OF HARM

16. What additional risk of harm to the patient or client might result from the proposed changes? How would your profession manage this risk?

In our view there is a significantly greater risk if patients are not administered oxygen when required as compared to receiving an inappropriate amount. It is the College’s opinion that having the Respiratory Therapist principally entrusted with the patient’s oxygen administration allows for a more consistent and coordinated approach.

In the unlikely event that there was to be an indiscriminate application of high levels of oxygen the greatest risk to adults would be oxygen toxicity, which can result in pulmonary tissue damage. However, the results of most studies indicate that adults can breathe up to 50% for extended periods without major lung injury. This can be avoided by limiting the adult client’s exposure to 100% oxygen to less than 24 hours and closely monitoring the partial pressure of oxygen in the client’s arterial blood (PaO2). According to human and animal studies, high concentrations of inspired oxygen can cause a spectrum of lung injury, ranging from mild tracheobronchitis (inflammation of the trachea and bronchi) to diffuse alveolar damage. Absorption atelectasis (where oxygen over 50% can reduce the nitrogen levels in the lungs and cause areas to collapse) can also occur with concentrations greater than 50%, particularly in client’s who are breathing at a low tidal volume (e.g.) sedation, surgical pain. CO2 narcosis can result in a depression in ventilation in clients predisposed to the disorder due to chronic hypercapnia (e.g.) COPD. Retinopathy of prematurity (ROP) is an abnormal eye condition that occurs in some premature or low-birth-weight infants (up to approx. 1 month of age) who receive supplemental oxygen. Currently resuscitation standards recommend keeping an infant’s arterial PO2 below 80mmhg as the best way of minimizing the risk of ROP. All of the above precautions and potential hazards could be managed through close monitoring that the RT would provide in collaboration with the rest of the health care team.

RTs routinely perform arterial saturation monitoring and arterial blood gas sampling as part of their clinical practice and these are the best methods of assessing the adequacy of oxygen administration. In current clinical practice patients sometimes remain on higher level of oxygen than necessary because there is no order for titration. Therefore, it is our position that having the RT at the bedside making the necessary adjustment when indicated will

---

significantly reduce the likelihood of this occurring. Permitting RTs to order/prescribe oxygen will enable closer monitoring of optimal and safe oxygen levels.

EDUCATION AND CONTINUING COMPETENCY

17. How does your profession require demonstration of competencies for pharmacotherapy?

Pharmacotherapy is taught in the RT programs and is examined in the entry-to-practice exam; the Canadian Board of Respiratory Care (CBRC). Both the educational programs and the CBRC examination are based on the National Competency Profile (NCP)\textsuperscript{4}. In the 2003 version of the NCP, 98% of the RTs in Ontario reported that they performed oxygen therapy as part of their clinical practice. A copy

During 2000-2005 the Canadian Society of Respiratory Therapists (CSRT) developed an Occupational Profile\textsuperscript{5} based on a national job analysis that was used as a blueprint for curriculum development, educational program evaluation and the national examination. The profile outlines the skills and knowledge required of a Respiratory Therapist and describes in detail the competencies required for safe application of oxygen therapy. The CSRT national accreditation program is provided through the Council on Accreditation for Respiratory Therapy Education (CoARTE). CoARTE accreditation provides a tool to assist respiratory therapy schools and regulatory bodies in assuring the public that the national educational standards for entry-level respiratory therapy have been met.

18. Please provide pharmacotherapy course content in the current educational curriculum and demonstrate how it ensures the minimum qualifications for the prescribing or administration of drugs by members of your profession.

Oxygen administration is taught extensively in the educational programs under “Medical Gases Therapy”. Attached is a copy of the portion of the Occupational Profile that outlines the knowledge component of oxygen therapy

19. Does the health professional college require continuing education and training for members to ensure competency in the prescribing or administration of drugs? Please be specific and provide documentation to the extent possible. Please describe how the college ensures its members keep pace with advancements in pharmacotherapy, pharmacology and patient safety.

It is an expectation outlined in the CRTO Standards of Practice\textsuperscript{6} document that CRTO Members demonstrate an understanding and analysis of both the equipment used in the practice of respiratory care and the various medical gas systems. Members are also required to maintain the competencies for the activities/procedures that he/she performs.

The CRTO’s Quality Assurance (QA) Program is outlined in detail in the Quality Assurance Regulation 596/94 Part VI\textsuperscript{7}. The Program is divided into two main components; the Continuous Quality Improvement, or CQI module, and the Assessment module. Members are required to participate in the CRTO’s QA program on an on-going basis. They are selected at random for assessment on a yearly basis and their knowledge of the application

\textsuperscript{4} National Alliance of Respiratory Therapy Regulatory Bodies, National Competency Profile. 2003


\textsuperscript{6} CRTO, Standards of Practice. 2004

\textsuperscript{7} Ont. Regulation 596/94, Part VI – Quality Assurance.
of legislative and regulatory requirements is tested at that time. Our Members are required to keep a professional portfolio which monitors their day-to-day learning and enables them to track at least one major learning objective each year.

20. Please indicate what college documents are available to members on the prescribing or administration of drugs, including relevant standards of practice, rules and guidelines. Are these documents current? Please include the documents with the submission.

The following documents deal generally with the practice of Respiratory Therapy, relevant to oxygen administration:

- CRTO Standards of Practice
- Interpretation of Authorized Acts Professional Practice Guideline
- Infection Prevention & Control Clinical Best Practice Guideline

In the event that this proposal is approved and Respiratory Therapists are permitted to prescribe/order oxygen, the CRTO would develop relevant guidelines and continuing education processes to specifically address the prescribing function.

21. Please describe current competencies, education and training of members of the profession to perform any of the proposed changes.

The administration of oxygen therapy is a core competency for RTs and so it is our opinion that no further education would be required. However, if this proposal was accepted, there would need to be education and guidance for our Members relevant to the responsibilities of prescribing and for those new members coming from jurisdictions where prescribing of oxygen is not part of the scope of practice of the profession.

22. Do all members of the profession have the competencies to perform any proposed activity related to the prescribing and/or administration of drugs?

Yes, as mentioned previously, oxygen administration (initiation, administration and titration) is a core competency for our Members. As outlined in the CSRT National Competency Profile, RTs are required to know the physical and chemical properties of oxygen, safety standards, delivery systems and devices, as well as the medical indications and hazards. We believe that in view of this knowledge, very little additional education would be required related to prescribing of oxygen.

23. What effect would the proposed change in the prescribing or administration of drugs have on members of your profession who are already in practice?

a) What additional competencies, education and training would be required for all (or some additional) members of the profession to perform any proposed activity.

Our Members would require some additional information of the rights and responsibilities around prescribing/ordering oxygen. However, in view of member's existing knowledge and skills, we believe that very little additional education would be required related to prescribing of oxygen.

b) How will the members become current with the changes, and how will their competency be assessed?
Should the act of prescribing/ordering of oxygen be granted our Members would be informed of the changes through the various mechanisms the CRTO utilizes to communicate (e-mail, regular mail, presentations, webinars, etc). A practice guideline would be developed and disseminated on the issue surrounding the prescribing/ordering of oxygen. The Professional Standards Assessment (see below) would be revised to include questions on prescribing oxygen.

c) What quality improvement or quality measurement programs do you have in place and what additional programs would be put into place?

As outlined above, the CRTO currently has a Quality Assurance program, participation in which is mandatory. The Professional Standards Assessment (PSA) portion of the QA program assesses the RTs' understanding of the legislation, regulations and practice guidelines governing the profession. The PSA would be revised to include questions on prescribing and a practice guideline on prescribing/ordering would be developed to address standards related to prescribing. As with all regulated health professions, our current program is also being revised to comply with amendments to the RHPA that will require all health regulatory colleges to have a QA program that incorporate advances in technology.

d) What educational bridging programs will be necessary for current members?

Members would require education on the responsibilities around prescribing/ordering. This would be provided both to the students by the educational programs and to the existing RTs by the CRTO. However, in view of member's existing knowledge and skills, we believe that very little additional education would be required related to prescribing of oxygen.

PUBLIC INTEREST
24. Describe how the proposed changes are in the public interest. Please consider and describe the influence of any of the following factors or other relevant matters:

a) Patient safety,

As mentioned previously, the delay in receiving oxygen that may be experienced by patients while awaiting an order for oxygen from a physician is unnecessary and potentially detrimental to the patient. Patients sometimes do not receive the oxygen they need when they need it, or do not have their oxygen titrated to an appropriate level when they should. Both scenarios can result in a deterioration of the patient’s condition which can lead to increased length of stays (LOS). Despite the fact that oxygen is an essential drug/substance, it is often overlooked in clinical practice and no orders are written in anticipation of a change in the patient’s oxygen requirements. Permitting RTs, who have extensive training and experience in oxygen therapy, to prescribe/order oxygen will enhance the ability of the health care team to respond to the patient's needs in a timely manner. This is of particular importance in more remote and rural facilities where there are fewer physicians and access to care is often more challenging.

Studies have found that patients with respiratory diseases experience significant inconsistencies in their in-hospital care regarding the application and titration of
oxygen, as well as consistent on-going monitoring of saturation and arterial blood gases.\(^8\)

b) Epidemiological trends in illness and disease,

The number of people affected by respiratory disease is increasing as the demographics in Canada shift to an aging population. This will lead to a corresponding increase in the demand for health care services.\(^9\) Canada is facing a substantial increase in the incidence of chronic respiratory disease due to a number of factors including:

- Increased prevalence of chronic obstructive pulmonary disease (COPD), particularly in women; Worldwide, COPD is the only leading cause of death that still has a rising mortality rate. It has been estimated that by the year 2020 COPD will be the third leading cause of death in the world.\(^10\)
- Increased prevalence and mortality rate of those suffering from lung cancer, also more so in women;
- Changing immigration patterns leading to an increase in incidence of tuberculosis;
- Increased life expectancy of individuals with cystic fibrosis.
- Poor indoor/ outdoor air quality;
- The influence of obesity on asthma and obstructive sleep apnea.
- Potential for high oxygen demands during pandemic respiratory influenza outbreaks such as was seen during SARS.

All of these and other factors are having a major impact on the ability of hospital and community services to deliver adequate care.\(^11\) The increased prevalence and hospitalization rates among women are becoming a crucial women’s health issue. Since 2000, female mortality due to COPD has risen at double the rate of breast cancer.\(^12\) Patients with COPD typically require oxygen therapy on an on-going basis and so the demand for such services will continue to increase in the coming years. This will impact both in-hospital and home care services.

c) Access to care and coordination of care,

We are unable to introduce new physicians into the community at the same rate they are leaving the medical profession. The health human resource shortage makes it essential that those caring for patients at the bedside and in their homes have the ability to meet their patient’s immediate needs. This will require a rethinking of traditional care plans and a move toward utilizing the full competencies of all personnel at the bedside. If Respiratory Therapists are able to utilize their education and experience in oxygen therapy, this will benefit not only the patients but the entire health care team.

---

9 Canadian Lung Association, National Lung Health Framework – Executive Summary. 2007
11 Public Health Agency of Canada. Life & Breath: Respiratory Disease in Canada. 2007
d) Wait times for health care services,

“Changing the way we educate health care professionals to work together, share responsibility and collaborate is key to increasing access to health care services - and, by extension, reducing wait times”.¹³ Delay in discharge from the hospital is often caused by waiting for a physician’s order to either titrate the patient off their oxygen or receive an order/prescription for oxygen in the home. This increases LOS which in turns creates unnecessary bottlenecks in the system and ties up much needed beds. Hospital wait times for in-patient beds have become a critical issue and dramatically impact services emergency departments’ ability to provide services. From the indicators listed above, it is reasonable to expect that there will be a significant increase in the number of patients with chronic respiratory diseases occupying hospital beds in the coming years. This will in turn impact the ability of emergency wait times and so maximizing efficiencies within the system are more important now than ever. Respiratory Therapists being able to order, initiate, titrate and wean patients off oxygen in a timely manner will likely result in a reduction in LOS for these patients and result in more available in-patient beds.

e) Best practices of the profession,

In recent years there has been a move away from "stat" physician orders, to a dynamic patient-focused model of care. Respiratory Therapists are well trained and experienced in all aspects of application of oxygen and can enable processes where the needs of the patient drive their care. The development of saturation criteria and oxygen administration guidelines can reduce excess oxygen use, decrease the length of patient days on oxygen and eliminate unnecessary application of oxygen. Standardized criteria would help eliminate the variation in a physician’s approach to ordering oxygen.

f) Promotion of collaborative practice,

Permitting RTs to order/prescribe oxygen will allow them to assist physicians, nurses, physiotherapists and other front-line staff by meeting their patient’s needs in a timely manner. Hospital staff often wastes valuable time calling physicians and waiting to obtain an order for oxygen.

g) Professional competencies not currently recognized.

Respiratory Therapists have extensive training and experience in the management of patient’s oxygen needs yet they are often limited or delayed in their ability to respond to the patient’s needs because there is no order for oxygen initiation or titration. Permitting RTs to prescribe/order oxygen would enable them to utilize their skills to the optimal benefit of the patient and the health care team.

25. How would the proposed change affect other health professions? The public? Describe the effect the proposed change in the prescribing and/or administration of drugs might have on:

a) Health human resources,

¹³ Health Canada. The Health Human Resource Cornerstone. (Speech by Tony Clement-title) 2006
Shortages in physician and nursing personnel make it all the more important to permit HCP to utilize the skills that they have. Enabling Respiratory Therapists to prescribe/ order oxygen would lighten the workload of physicians and allow them to attend to other matters. Nursing staff would no long have to call physicians who were out of the hospital to obtain orders for oxygen administration.

b) Enhancement of quality of services,

Proposed changes would speed the delivery of care by permitting the RT and nursing staff at the bedside to respond to the changing condition of their patients. If the Respiratory Therapists were responsible for oxygen prescribing/ordering in a hospital it could help to reduce variability in assessment and ordering practices.

c) Access to services,

This would permit all patients, but particularly those in more rural and remote settings, to receive the oxygen they need in a timely manner. Limited access to physicians make obtaining orders for oxygen therapy even more difficult particularly in underserviced areas of the province.

d) Service efficiency,

Discharge is often delayed because while the patient is medically stable, there is no order to titrate them off their oxygen. If the RT was able to initiate this titration process it would potentially result in reduced LOS due to being able to efficiently wean patients off their oxygen. Also, if RTs were permitted to write orders for home oxygen this would eliminate the often lengthy and costly delay of discharge of medical stable patients who require oxygen at home.

e) Interprofessional care delivery, and

Permitting RTs to order/prescribe oxygen will allow them to assist physicians, nurses, physiotherapists and other front-line staff by meeting their patient’s needs in a timely manner. Hospital staff often wastes valuable time calling physicians and waiting to obtain an order for oxygen.

f) Other impacts.

26. Are members of your profession in favour of the proposed changes? Please describe any consultation process and the response achieved.

This proposal was discussed and approved in principle at the Annual General Meeting of the Respiratory Therapy Society of Ontario (the provincial professional association). We have attached a letter of support from the RTSO.

PRESCRIBING: DRUG REGULATIONS UNDER PROFESSIONAL ACTS
27. Please describe challenges faced by members of the profession as a result of listing specific drugs in regulation schedules made under the profession-specific act.
The CRTO is requesting that members of the College have the authority to prescribe only oxygen at this time. Therefore, issues regarding lists, categories and classes of drugs are not applicable.

28. If classes of drugs, rather than a list of specific drugs, were included in the proposed regulations, please describe how this would impact the members of the profession and the college. What, if any, additional education and training, competency review, or updates to clinical guidelines or standards of practice would be required?

29. If classes of drugs, rather than a list of specific drugs were included in the regulation, what conditions should be attached, if any, to the classes? Should the broad purpose, indications, or some other reference be specified (e.g. for pain relief in labour; for smoking cessation; for treatment of sexually transmitted diseases; in emergency; refill). Please comment in detail.

30. If classes of drugs, rather than a list of specific drugs were included in the regulation, how would you classify the drugs for your profession? Are there circumstances where a drug class would not be appropriate in a regulation schedule for the profession? Are there situations where a combination of class and list of specific drugs would better respond to the competencies of the profession?

31. If applicable, please describe in general your profession’s experience with requests for changes to drug regulations, including specifics of the requests made, regulation changes that followed, if possible the time required for changes to regulations, and what, if any, proposed changes were, or were not, approved by government. None

COLLABORATION

32. Do members of your profession practice in a collaborative or team environment where a change in drug regulations or legislation would contribute to multidisciplinary health care delivery? How would relations between professionals working in a team be impacted? What additional standards would be required (e.g., record-keeping, referral protocols) Please describe any consultation process, agreements or other arrangements that have occurred with other professions.

If the ability for Respiratory Therapists to prescribe/ order oxygen is considered, the CRTO would initiate a consultation with key stakeholders (College of Physician and Surgeons of Ontario, College of Nurses of Ontario, College of Physiotherapists of Ontario, etc) in order to gain their input into how best to implement this new process.

OTHER JURISDICTIONS

33. Describe any obligations or agreements on trade and mobility that may be affected by the proposed changes for the profession. What are your plans to address any trade/mobility issues?

The respiratory therapy regulators are signatories to a Mutual Recognition Agreement who have agreed upon common occupational standards and principles as a basis for the MRA. This MRA acknowledges the authority of each regulatory body to set standards and requirements and recognizes that the ultimate responsibility for assessing whether applicants may safely practice the profession is the right of the regulatory bodies of each jurisdiction. The MRA also recognizes each regulator’s right and responsibility for ensuring competence through a quality assurance program. In addition, the signatories to the MRA base their jurisdiction’s curricula and assessment on a National Competency Profile. It may be necessary to ensure that members who are registered under the MRA are required to
familiarize themselves with any activities related to prescribing oxygen.

34. What is the experience in other Canadian jurisdictions? What is the experience in international jurisdictions?

COSTS AND BENEFITS
35. What are the potential costs and benefits to the public and the profession of the proposed changes? Please consider and describe the economic impact, costs and benefits to:

a) patients,

There is significant potential cost savings due to decrease LOS. A coordinated approach to oxygen therapy that empowers the RT to make the necessary changes would result in less time spent on oxygen, reduce adverse outcomes related to oxygen therapy, and enable timely patient discharge for those requiring home oxygen.

b) broader health care service delivery system,

We also predict that there would be a reduction in health care costs due to a decrease in equipment costs and a decrease in bulk oxygen use. Ensuring that each patient receives the right amount of oxygen for the appropriate amount of time has been shown to decreased patient LOS. This will free up much needed hospital beds.

c) educational sector,

There would be no additional cost to the educational sector, as the knowledge of oxygen administration is already a core part of the curriculum.

d) regulatory sector, and

We also do not anticipate an additional cost to the College, as the responsibilities around prescribing/ordering could be easily incorporated within our current professional practice and QA processes.

e) the profession.

Permitting Respiratory Therapists to prescribe/order oxygen would enable them to provide optimal care to their patient when it is needed and permit them to utilize their competencies.

14 London Health Sciences, Breathing Easier Program. 1996
ADDITIONAL INFORMATION

36. Is there any other relevant information that HPRAC should consider when reviewing your submission?

- Amendments to the Public Hospitals Act
- Funding under the Assistive Devices Program

Documents included:

- National Competency Profile – page 21.
- Occupational Profile – pages 68 & 69.
- Mutual Recognition Agreement
- Letter of support from the Respiratory Therapy Society of Ontario
## National Entry-Level Competencies

### % - The percent of Respiratory Therapists that perform the competency
The % will be within a range of 0 - 100

### FI - The Frequency & Impact rating of Respiratory Therapists that perform the competency
The FI Rating will be within a range of 4 - 36

<table>
<thead>
<tr>
<th>N</th>
<th>Basic Respiratory Care</th>
<th>CANADA</th>
<th>BC</th>
<th>A</th>
<th>S</th>
<th>M</th>
<th>O</th>
<th>Q</th>
<th>NB</th>
<th>NS/IP</th>
<th>N/L</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1</td>
<td>Provide oxygen therapy</td>
<td>% 97</td>
<td>100</td>
<td>97</td>
<td>100</td>
<td>98</td>
<td>96</td>
<td>94</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 35</td>
<td>35</td>
<td>36</td>
<td>35</td>
<td>36</td>
<td>36</td>
<td>34</td>
<td>33</td>
<td>31</td>
<td>36</td>
</tr>
<tr>
<td>N2</td>
<td>Provide humidity therapy</td>
<td>% 91</td>
<td>100</td>
<td>92</td>
<td>100</td>
<td>86</td>
<td>97</td>
<td>87</td>
<td>88</td>
<td>86</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 32</td>
<td>31</td>
<td>33</td>
<td>29</td>
<td>35</td>
<td>33</td>
<td>31</td>
<td>31</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td>N3</td>
<td>Provide aerosol therapy</td>
<td>% 96</td>
<td>100</td>
<td>96</td>
<td>100</td>
<td>97</td>
<td>97</td>
<td>88</td>
<td>86</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 34</td>
<td>35</td>
<td>34</td>
<td>30</td>
<td>35</td>
<td>34</td>
<td>33</td>
<td>32</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>N4</td>
<td>Perform oropharyngeal suction therapy</td>
<td>% 92</td>
<td>100</td>
<td>93</td>
<td>73</td>
<td>86</td>
<td>92</td>
<td>92</td>
<td>81</td>
<td>71</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 33</td>
<td>35</td>
<td>32</td>
<td>32</td>
<td>36</td>
<td>35</td>
<td>31</td>
<td>30</td>
<td>32</td>
<td>35</td>
</tr>
<tr>
<td>N5</td>
<td>Perform nasopharyngeal suction therapy</td>
<td>% 86</td>
<td>100</td>
<td>86</td>
<td>82</td>
<td>86</td>
<td>90</td>
<td>83</td>
<td>69</td>
<td>71</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 31</td>
<td>33</td>
<td>30</td>
<td>31</td>
<td>29</td>
<td>34</td>
<td>29</td>
<td>31</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>N6</td>
<td>Perform endotracheal suction therapy</td>
<td>% 88</td>
<td>96</td>
<td>88</td>
<td>82</td>
<td>86</td>
<td>90</td>
<td>88</td>
<td>63</td>
<td>71</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 34</td>
<td>36</td>
<td>33</td>
<td>33</td>
<td>36</td>
<td>35</td>
<td>32</td>
<td>35</td>
<td>34</td>
<td>36</td>
</tr>
<tr>
<td>N7</td>
<td>Assist with thoracic suction or drainage therapy</td>
<td>% 45</td>
<td>63</td>
<td>67</td>
<td>45</td>
<td>71</td>
<td>45</td>
<td>34</td>
<td>25</td>
<td>57</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 27</td>
<td>25</td>
<td>27</td>
<td>30</td>
<td>25</td>
<td>24</td>
<td>19</td>
<td>25</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>N8</td>
<td>Perform sputum collection procedures</td>
<td>% 79</td>
<td>89</td>
<td>83</td>
<td>79</td>
<td>79</td>
<td>85</td>
<td>74</td>
<td>69</td>
<td>71</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 28</td>
<td>25</td>
<td>26</td>
<td>22</td>
<td>24</td>
<td>27</td>
<td>30</td>
<td>24</td>
<td>28</td>
<td>31</td>
</tr>
<tr>
<td>N9</td>
<td>Provide thermal regulation (warming, cooling, maintaining)</td>
<td>% 55</td>
<td>70</td>
<td>54</td>
<td>36</td>
<td>36</td>
<td>46</td>
<td>60</td>
<td>38</td>
<td>57</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 28</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td>28</td>
<td>29</td>
<td>15</td>
<td>19</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>N10</td>
<td>Teach incentive spirometry</td>
<td>% 71</td>
<td>78</td>
<td>68</td>
<td>45</td>
<td>43</td>
<td>60</td>
<td>80</td>
<td>75</td>
<td>71</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 23</td>
<td>18</td>
<td>23</td>
<td>19</td>
<td>25</td>
<td>20</td>
<td>25</td>
<td>26</td>
<td>20</td>
<td>32</td>
</tr>
<tr>
<td>N11</td>
<td>Apply pulmonary re-education techniques (eg. secretion clearance, relaxation techniques)</td>
<td>% 78</td>
<td>85</td>
<td>79</td>
<td>73</td>
<td>64</td>
<td>77</td>
<td>78</td>
<td>81</td>
<td>86</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 24</td>
<td>22</td>
<td>26</td>
<td>18</td>
<td>26</td>
<td>23</td>
<td>26</td>
<td>24</td>
<td>17</td>
<td>31</td>
</tr>
<tr>
<td>N12</td>
<td>Assist with speech therapy (breathing techniques)</td>
<td>% 66</td>
<td>63</td>
<td>53</td>
<td>64</td>
<td>43</td>
<td>57</td>
<td>83</td>
<td>50</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 22</td>
<td>17</td>
<td>23</td>
<td>23</td>
<td>24</td>
<td>21</td>
<td>26</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N13</td>
<td>Assist with body positioning techniques</td>
<td>% 71</td>
<td>78</td>
<td>71</td>
<td>64</td>
<td>43</td>
<td>71</td>
<td>74</td>
<td>56</td>
<td>43</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 25</td>
<td>26</td>
<td>25</td>
<td>19</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>N14</td>
<td>Insert oral/nasogastric tubes</td>
<td>% 47</td>
<td>56</td>
<td>36</td>
<td>36</td>
<td>14</td>
<td>38</td>
<td>61</td>
<td>38</td>
<td>14</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 29</td>
<td>29</td>
<td>25</td>
<td>31</td>
<td>30</td>
<td>28</td>
<td>29</td>
<td>25</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>N15</td>
<td>Maintain gastric suction</td>
<td>% 37</td>
<td>44</td>
<td>35</td>
<td>9</td>
<td>21</td>
<td>22</td>
<td>48</td>
<td>13</td>
<td>57</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FI 24</td>
<td>20</td>
<td>24</td>
<td>8</td>
<td>32</td>
<td>23</td>
<td>27</td>
<td>18</td>
<td>23</td>
<td>31</td>
</tr>
</tbody>
</table>
F  GENERAL THERAPEUTICS

Main Competency

1. Provide oxygen therapy.

<table>
<thead>
<tr>
<th>Background</th>
<th>Eval</th>
<th>User</th>
</tr>
</thead>
<tbody>
<tr>
<td>k. Describe the emergency action required for major leakage from a gas wall outlet.</td>
<td>Wi</td>
<td></td>
</tr>
<tr>
<td>l. Explain the general principles of operation of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• flowmeters (horpe tube and bourdon gauge)</td>
<td>W</td>
<td></td>
</tr>
<tr>
<td>• pressure reducing valves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• regulators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Describe general principles of the following gas mixing devices:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• blender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• mixer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• venturi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Describe low flow devices including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• nasal cannula</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• nasopharyngeal catheters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• non-rebreathing mask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• OCD (oxygen conserving device)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• simple mask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• transtracheal catheter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o. Describe high flow, (variable and fixed) entrainment devices including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• high air flow oxygen enrichment (HAFOE) masks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• entrainment nebulizers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• high flow valve/blending devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p. Compare high and low flow devices in terms of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• gas source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• air and oxygen ratios</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• factors affecting concentrations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• humidity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• indications for use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>q. List methods of quality control for gas controlling and delivery devices.</td>
<td>Wi;</td>
<td></td>
</tr>
<tr>
<td>r. Explain the principles of operation of the electrochemical oxygen analyzers.</td>
<td>Wi;</td>
<td></td>
</tr>
<tr>
<td>s. Describe the calibration of the electrochemical oxygen analyzers.</td>
<td>Wi;</td>
<td></td>
</tr>
<tr>
<td>t. Describe the advantages and disadvantages of the following analyzers:</td>
<td>Wi;</td>
<td></td>
</tr>
<tr>
<td>• galvanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• polarographic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>u. Discuss the factors which affect the efficiency and accuracy of oxygen analyzers.</td>
<td>W</td>
<td></td>
</tr>
<tr>
<td>v. Discuss the following indications for oxygen therapy:</td>
<td>W</td>
<td></td>
</tr>
<tr>
<td>• hypoxemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• increased myocardial work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• increased work of breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• pulmonary hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>w. Discuss the hazards of oxygen therapy.</td>
<td>W</td>
<td></td>
</tr>
<tr>
<td>• absorption atelectasis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• combustion support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• oxygen toxicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• retinopathy of prematurity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• induced hypoventilation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F  GENERAL THERAPEUTICS

Main Competency

1. Provide oxygen therapy.

<table>
<thead>
<tr>
<th>Sub-Competency</th>
<th>Age</th>
<th>Lev</th>
<th>Eval</th>
<th>User</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Assess the need for oxygen therapy.</td>
<td>APN</td>
<td>A</td>
<td>Dc</td>
<td></td>
</tr>
<tr>
<td>b. Select appropriate gas supply system.</td>
<td></td>
<td>A</td>
<td>Dc</td>
<td></td>
</tr>
<tr>
<td>c. Apply delivery equipment.</td>
<td>APN</td>
<td>A</td>
<td>Dc</td>
<td></td>
</tr>
<tr>
<td>• low flow devices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• high flow devices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Monitor therapy.</td>
<td>APN</td>
<td>A</td>
<td>Dc</td>
<td></td>
</tr>
<tr>
<td>e. Evaluate treatment plan.</td>
<td>APN</td>
<td>A</td>
<td>Dc</td>
<td></td>
</tr>
<tr>
<td>f. Make adjustments as required.</td>
<td>APN</td>
<td>A</td>
<td>Dc</td>
<td></td>
</tr>
<tr>
<td>g. Recognize complications and take action.</td>
<td>APN</td>
<td>A</td>
<td>Ds</td>
<td></td>
</tr>
<tr>
<td>h. Educate patient and patient caregivers as required.</td>
<td>AP</td>
<td>A</td>
<td>Dc</td>
<td></td>
</tr>
<tr>
<td>i. Ensure quality control.</td>
<td></td>
<td>A</td>
<td>Ds</td>
<td></td>
</tr>
<tr>
<td>j. Wean patient from oxygen therapy. (Supplemental)</td>
<td>APN</td>
<td>A</td>
<td>Dc</td>
<td></td>
</tr>
<tr>
<td>k. Prepare patient for discharge with oxygen. (Supplemental)</td>
<td></td>
<td>A</td>
<td>Dc</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td></td>
<td>Dc</td>
<td></td>
</tr>
</tbody>
</table>
NATIONAL COMPETENCY PROFILE

The following agreement is created on the basis of mutual respect, trust and understanding that a common national competency profile will be implemented by all signatories to this agreement. This agreement is subject to ratification by the Boards/Councils of the signatories following a unanimous endorsement by the representatives of the signatories on November 17, 2002, to approve the following Mutual Recognition Agreement.
MUTUAL RECOGNITION AGREEMENT FOR RESPIRATORY THERAPISTS:
NOVEMBER 17, 2002

1 Purpose
1.1 The purpose of this agreement is to promote the mobility and access to employment opportunities of respiratory therapists, pursuant to the Agreement on Internal Trade.

2 Definitions
2.1 In this agreement:
2.1.1 “applicant” means a person who is a respiratory therapist with any regulatory body in Canada, or is practising as such in an unregulated jurisdiction in Canada as a registered member of the CSRT, and wishes to practise in another jurisdiction;
2.1.2 “CARTA” means the College and Association of Respiratory Therapists of Alberta;
2.1.3 “commonality” means approximately 80% equivalency as agreed to by the parties;
2.1.4 “continuing competency program” means the maintenance of ongoing knowledge, skills and abilities/judgement to practice the profession safely (may include “quality assurance program”, “mandatory continuing education”, or a similar program);
2.1.5 “CRTO” means the College of Respiratory Therapists of Ontario;
2.1.6 “CSRT” means the Canadian Society of Respiratory Therapists;
2.1.7 “legislation” includes legislation, regulations, by-laws and other legally binding provisions;
2.1.8 “licence” includes “registration” or a “certificate of registration” or a “practice permit”;
2.1.9 “MARRT” means the Manitoba Association of Respiratory Therapists;
2.1.10 “member” means an individual who is licensed or registered by or holds a certificate of registration or a practice permit with a regulatory body, or is a registered member of the CSRT practising in an unregulated jurisdiction;
2.1.11 “OPIQ” means the Ordre professionnel des inhalothérapeutes du Québec;
2.1.12 “registered” means that an individual holds a licence with a regulatory body or is a registered member of the CSRT practising in an unregulated jurisdiction, that is not a graduate, provisional, temporary or student licence;
2.1.13 “regulatory body” means any organization with the statutory authority to regulate respiratory therapists within a province or territory of Canada; specifically CARTA, CRTO, MARRT and OPIQ;
2.1.14 “respiratory therapist” includes “respiratory care practitioner”; “inhalothérapeute”; “technicien en inhalothérapie et anesthésie” “thérapeute respiratoire”; “praticien des soins respiratoires”; “technician in inhalation therapy and anaesthesia”; “respiratory technologist” or any other title which describes the professional;
2.1.15 "the profession" means "respiratory therapy"; "respiratory care"; "inhalement"; "thérapie respiratoire"; "soins respiratoires"; and "inhalation therapy", "respiratory technology", or any other title which describes the profession;

3 Principles

3.1 This mutual recognition agreement does not limit the authority of each regulatory body or the CSRT to set standards and requirements and recognizes that the ultimate responsibility for assessing whether applicants may safely practice the profession is the right of the regulatory bodies of each jurisdiction.

3.2 All parties recognize that the ongoing demonstrated competence of an individual through their practical work experience in addition to the existence of a regulatory model which includes entry to practice requirements, accreditation of educational programs, the use of a quality assurance program that assesses continuing competence, and a complaints and discipline system, is the basis upon which this mutual recognition agreement is founded.

3.3 All parties acknowledge that there is a significant overlap in the practice of the profession in all provincial and territorial jurisdictions and that there is at least 80% overlap between the entry to practice competencies required to obtain a licence with each of the regulatory bodies.

3.4 While there are differences in the models used to evaluate entry to practice competencies and differences in the weighting or importance associated with the various competencies, all parties acknowledge that at least some outcome measures are used by each of the regulatory bodies.

3.5 All parties acknowledge that the mutual recognition agreement is based on trust and the assurance by each regulatory body that it fulfils its statutory requirements and as a result its members meet a provincially or territorially defined standard.

3.6 Each jurisdiction will have legislation and standards of practice that are specific to their jurisdiction.

4 Mobility Rights

4.1 A person licensed as a "Registered Respiratory Therapist"; "Registered Respiratory Care Practitioner"; "inhalement"; "technicien en inhalothérapie et anesthésie" or a "Technician in Inhalation Therapy and Anaesthesia" on application, shall be licensed by the other regulatory body without restrictions other than those imposed on all members, subject to the conditions set out in this agreement.

4.2 Applicants must be registered with a regulatory body or be a registered member of the CSRT practising in an unregulated jurisdiction, and provide evidence of practising the profession within that jurisdiction for a minimum of 720 hours within the previous four years before being entitled to exercise the rights under this agreement.

4.3 This agreement does not apply to individuals who hold a graduate, provisional, temporary or student licence.
5  **Procedural Requirements**

5.1 Applicants will be required to complete an application form, prescribed by the regulatory body, or the CSRT, that is consistent with this agreement.

5.2 Applicants will be required to pay the fees and dues established by the regulatory body, or the CSRT, to which they apply. Those fees and dues shall not exceed those fees and dues paid by other applicants.

6  **Examination/Evaluation Process**

6.1 A regulatory body, or the CSRT, shall not require additional examinations or evaluations of applicants except as provided for by specific legislative requirements in any jurisdiction. Applicants may be required to demonstrate effective communication skills in English and/or French in a health care environment.

7  **Supervision of Practice or Continuing Competency Programs**

7.1 Each regulatory body, or the CSRT, agrees to maintain supervision of practice or a continuing competency program.

8  **Additional Licensing Requirements**

8.1 A regulatory body may impose additional requirements for licensing relating to the immigration status, professional misconduct, incompetence, and physical or mental capacity of an applicant. Those requirements shall be no more onerous than those imposed on other applicants.

8.2 A regulatory body may impose the same terms, conditions or limitations that were imposed on the applicant by the original regulatory body.

9  **Legislative Amendments**

9.1 To the extent that a regulatory body’s enabling legislation is inconsistent with the mobility rights protected by this agreement, that regulatory body shall actively seek amendment to the legislation.

10  **Administration of this Agreement**

10.1 The regulatory bodies, and the CSRT, who are signatories to this agreement, agree to establish and maintain a monitoring committee consisting of at least one and no more than two representatives from each jurisdiction who will be responsible for the implementation, maintenance, monitoring, assessment, problem-solving and dispute settlement associated with the terms and conditions of this agreement.
10.1.2 All expenses of the members of the monitoring committee are the responsibility of their respective signatory organizations.

10.1.3 The signatories to this agreement agree to review the operation of this agreement every five years, or as required.

10.1.4 The signatories shall provide twelve months' advance notification in writing, with reasons, for withdrawing from this agreement.

10.2 The content of this agreement may be amended, in particular, by the addition of other regulatory bodies or professional associations in unregulated jurisdictions. The unanimous and written consent of the signatories to the agreement is then required.

On behalf of CARTA:

[Signature]

Date: Nov 17/02

President

Registrar

On behalf of CRTO:

[Signature]

Date: Nov 17/02

President

Registrar

On behalf of MARRT:

[Signature]

Date: Nov 17/02

President

Registrar

On behalf of OPIQ:

[Signature]

Date: Nov 17/02

President

Registrar

On behalf of CSRT:

[Signature]

Date: 11/1/02

President

Registrar

Witness: Patty Wickson

[Signature]

Date: 2002-11-17

Witness: Patrick Litwin

[Signature]
November 11, 2008

Carole Hamp RRT CAE
Professional Practice Advisor
College of Respiratory Therapists of Ontario
Ordre Des Therapeutes Respiratories de L’Ontario
180 Dundas Street W. Suite 2103
Toronto, ON M5G 1Z8

Dear Carole:

Re: Respiratory Therapy Society of Ontario support for Oxygen Prescription

The Respiratory Therapy Society of Ontario (RTSO) accepts and endorses the College of Respiratory Therapists of Ontario (CRT0) submission regarding Oxygen Prescription/Ordering by Respiratory Therapists as outlined in the Review of Non-Physician Prescribing and Administration of Drugs under the Regulated Health Professions Act. This initiative, which is intended to improve the efficiency with which patients oxygen needs are met, has the support of the RTSO Board of Directors.

Sincerely,

RESPIRATORY THERAPY SOCIETY OF ONTARIO

Noreen Chan, RRT
President