



CJRT · RCTR

Forum 2006, Volume 42 (2)



Waves of Change — CSRT Educational Forum
May 25 – 28, 2006, Saint John, New Brunswick

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The journal for respiratory health
professionals in Canada

La revue des professionnels de la santé
respiratoire au Canada



**Canadian Journal of
Respiratory Therapy**
**Revue canadienne de la
thérapie respiratoire**

**Official Journal of the CSRT
Revue officielle de la SCTR**

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Courtesy of Tourism New Brunswick

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Welcome to the Forum Issue of the CJRT

Welcome to the Forum issue of the *CJRT*. This is always a great journal because we get to talk about our national event, celebrating the many accomplishments of respiratory therapists in Canada. This is your opportunity to see old friends, meet new friends, learn about cutting edge advances in your profession and to participate in some entertaining extra-curricular activities.



Doug Maynard

I would like to thank Katrina Madsen, the Chair of the local organizing committee, Darcy Andres, the National Forum Coordinator and Rita Hansen at CSRT Head Office for the incredible amount of work that has been logged to date. There are also a number of other volunteers on the ground in Saint John that have dedicated many hours to bring you a event that features some of the top researchers and opinion leaders in our profession.

This convention would also not be possible without our sponsors. A full list of sponsors for Forum 2006 can be found in this issue and on our website, www.csrt.com.

Some exciting developments this year include a record number of abstract submissions for poster presentations at the event, presentations from internationally recognized speakers and a full day of sessions dedicated to the educator's congress.

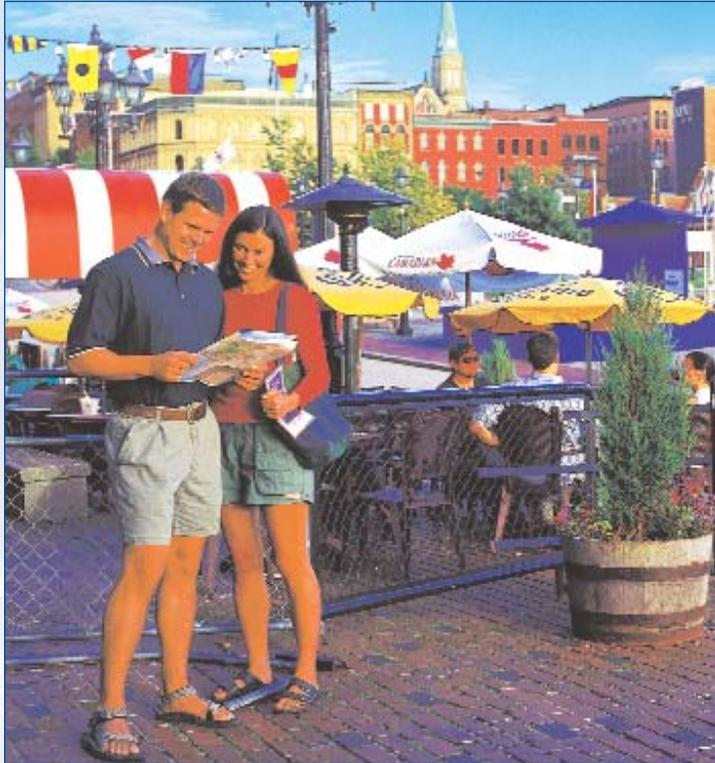
This event isn't only about research and education! Let's not forget all of those extra-curricular activities. We have will be having a wine and cheese reception to open the exhibit hall and to unveil our history book — painstakingly documented by long-standing CSRT past-president, Michael Andrews; a pub crawl tour of local establishments; a banquet featuring CBC personality, Arthur Black and as always, the Sputum Cup.

I look forward to seeing you all in Saint John so we can all experience some of that world famous Maritime hospitality!

Doug Maynard, BSc, RRT, MBA
Executive Director, CSRT
dmaynard@csrt.com

On Air

Welcome to the Beautiful City of Saint John



Photos courtesy of Tourism NB

Join us Friday night for our Boardwalk Pub Crawl

Thank You Forum Committee Saint John

The CSRT would like to extend it's heart-felt thanks to the volunteers who have worked so hard on the Saint John Forum. Our success is measured by the efforts of our volunteers. Thank you!

Darcy Andres — CSRT Forum Chair

Local Forum 2006 Organizing Committee:

Local Chair: Katrina Madsen
Educational: David Arbeau and Tammie Fournier
Registration: Carolyn McCoy
Social Chair: Stacie Field

| | |
|------------------|---------------|
| Tara McGraw | Lydia Morin |
| Lyndsey McKiel | Nicole Martin |
| Bonnie Blanchard | Cliff Donally |
| Jennifer Briggs | Amanda Flynn |
| Chantal Brideau | Naida Koteff |



Imperial Theatre, King's Square

CSRT Award Winners — The Stars

CSRT Medal Winners

Highest achievement on 2005 CSRT National Examination

Gold Medal Kelly Deslauriers

The Michener Institute for Applied Health Sciences, Ontario

Silver Medal Lewis Rempel

University of Manitoba — School of Medical Rehabilitation, Manitoba

Bronze Medal Russel Lear

Thompson Rivers University, British Columbia

Trudell Winners

*Highest score for first-time
writer of the 2005 CSRT
National Examination*

Russel Lear
Thompson Rivers University

Nicole Garden
Northern Alberta Institute of
Technology

Prabhjot Gill
Southern Alberta Institute of
Technology

Lewis Rempel
University of Manitoba,
School of Medical
Rehabilitation

Abby Stewart
Fanshawe College of Applied
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Applied Health Sciences

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de technologie

Frances Harvey
Vanier College

Iris Hood and Ghulam Nabi
New Brunswick Community
College, Saint John

Erin Riley
QEII/Dalhousie School of
Health Sciences

Deborah Blagdon
College of the North Atlantic

On Air Nuggets

New RT Program in Ontario

Conestoga College has recently developed a new Respiratory Therapy (RT) Program. The program is being modeled on Southern Alberta Institute of Technology's RT program. Conestoga College has been granted "Approval Status" from the Council on Accreditation for Respiratory Therapy Education (CoARTE) and is currently accepting student applicants for September 2006.

For more information on the program please contact Lori Pepler-Beechey, RT Program Coordinator, by e-mail at lpepler-beechey@conestogac.on.ca.

For more information on Conestoga College, please visit their web site at www.conestogac.on.ca

CSRT O₂ Café

Once again the CSRT is offering delegates a quiet spot to go on-line and check your email. Stop by the CSRT O₂ Café located in the Exhibit Hall, booth 50 and 51 and send a quick note home or check-in with the office. Also in the booth will be some of our new merchandise — embroidered golf shirts, short-sleeved t-shirts as well as our CSRT scrubs and long-sleeved ts. Copies of the CSRT history book — *The Early Years*, will also be available.

Educator's Congress May 25, 2006

Space is limited for this all-day event. Speakers include:

The Brain and Learning

Ian Patrick

Development of an Advisory

Ray Hubble

Interdisciplinary Education: A Partnership Approach Best Practices Workshop

Deborah MacLatchy

Lunch is included. Details can be found on pages 9 and 10. Registration does not include the CSRT Educational Forum.

July Exam

The sitting of the next CSRT National Certification Examination is July 10, 2006. The deadline for application is April 30, 2006. Please check the CBRC website for details www.cbrc.ca

Calendar of Events

May 13, 2006

Pediatric Sleep Disorders Meeting

Memphis, Tennessee

May 19 – 24, 2006

American Thoracic Society, 2006 International Conference

San Diego, California

May 16 – 20, 2006

American Society of Hypertension

21st Annual Scientific Meeting and Exposition

Linking Blood Pressure and Cardiovascular Health

Hilton New York, New York City

May 19 – 24, 2006

The American Thoracic Society International Conference

San Diego, California

www.thoracic.org/ic/ic2005/conference.asp

May 24 – June 5, 2006

Tuberculosis 2006 Conference

Kololi, Gambia

<http://mangosee.com/mangosteen/tb2006/tb2006.htm>

May 25, 2006

CSRT Educator's Congress

Saint John, New Brunswick

www.csrt.com

May 26 – 28, 2006

Canadian Society of Respiratory Therapists Educational Conference

Saint John, New Brunswick

www.csrt.com

June 8 – 11, 2006

The 3rd World Conference Respiratory Disease in Primary Care — Quality of Care

Oslo, Norway

www.theipcr.org/oslo2006/

June 11 – 15, 2006

Infection & Allergy of the Nose, 25th International Symposium

Tampere, Finland

<http://www.ers2006isian.com/>

June 10 – 14, 2006

European Academy of Allergology & Clinical Immunology, 25th Congress

Vienna, Austria

June 18 – 21, 2006,

Association of Polysomnographic Technologists 28th Annual Meeting

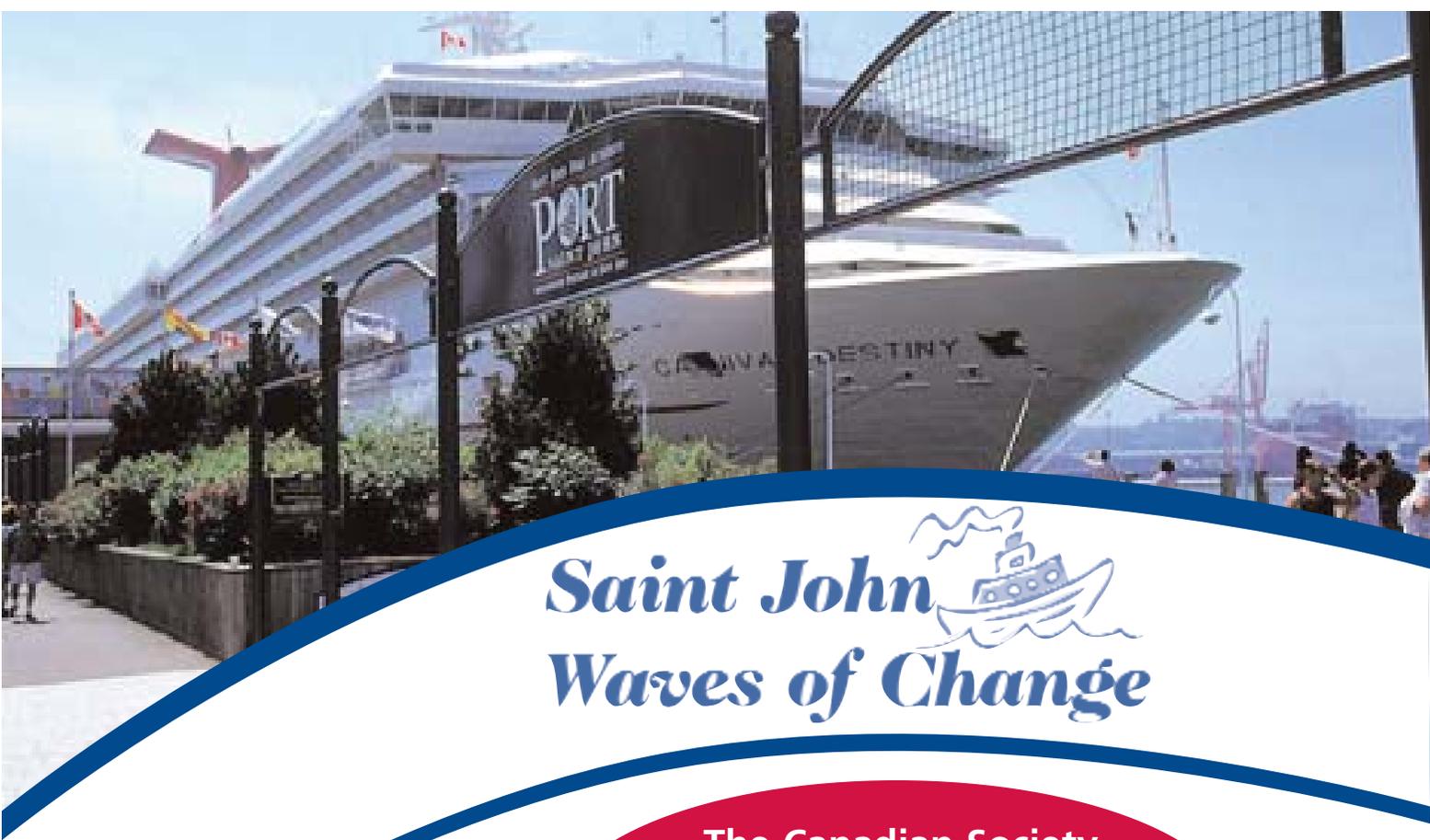
Salt Lake City, Utah

June 16 – 20, 2006

62nd Annual Meeting CVAS

Toronto, Ontario

http://www.cas.ca/annual_meeting/



Saint John Waves of Change

The Canadian Society
of Respiratory Therapists
Educational Forum



May 25–28, 2006
Saint John, NB
Saint John Trade and Convention Centre

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CSRT Educational Forum programme

May 25, 2006 – **thursday**

Educator's Congress — From 8:00 am to 5:00 pm Thursday

Location: Montagu Rooms 1 & 2

(See Page 19 for Separate Registration)

8:00 – 8:45 am

Registration

Welcome and Opening Remarks

Carolyn McCoy BHS RRT RPSGT, Coordinator/Instructor, Respiratory Therapy Program, NBCC Saint John

8:45 – 9:45 am

The Brain and Learning

Ian Patrick BA Med

Much of what we had come to understand from the field of psychology was fully supported by researchers in the neuro sciences, most notably that every human being is different, in part because while each brain may function in similar ways, each also tends to do so in ways that are singular. That, in turn, led me to a renewed interest in topics related to the unique ways in which people learn, with the result that eventually I began to look into the idea of personal styles of learning. While there are many methods of defining and discerning styles, I have found that they have much in common. Most importantly, they inform and challenge the conventional wisdom behind how society organizes the mass delivery of education.

In May, I will be drawing attention to some of the basic questions that drive me. For example, we will spend some time coming to grips with the vastness that is the human brain, what is good for it and what is not. The principal focus, however, will be upon our inherent day-to-day uniqueness as learners. We all have our own learning preferences or styles. Our conscious acknowledgement of that is important.

10:00 – 11:00 am

Development of an Advisory Council

Ray Hubble RRT MMed, CSRT Director of Education and Clinical Standards

11:15 – 12:15 pm

Interdisciplinary Education at the University of New Brunswick: A Partnership Approach

Deborah MacLatchy, Dean, Faculty of Science, Applied Science and Engineering, University of New Brunswick

The Bachelor of Health Sciences degree at the University of New Brunswick (Saint John) is normally a four-year program of studies consisting of two years of university education and two years of instruction and practical skills training in a particular professional stream. The four streams currently available include: Radiography, Respiratory Therapy, Nuclear Medicine and Radiation Therapy. The formal partnerships in the program are with the New Brunswick Community College, Saint John, Saint John Regional Hospital (Atlantic Health Sciences Corporation) and the Moncton Hospital School for Radiologic Technology (South-East Regional Health Authority) for the provision of didactic studies and clinical teaching for this program. Established in 1997, the program was developed to prepare medical technologists and therapists with the skill mixture to address changing needs in the Canadian health care system. Grounded in a year of university course work in the sciences, the two years of didactic and clinical available at partner institutions results in skilled practitioners in the field of medical technology. Through upper level course work in, for example, the social and health sciences, the practice issues are explored and contextualized and critical thinking and decision-making based



CSRT Educational Forum Programme

- 11:15 – 12:15 pm on evidence is further developed. Following an overview of the program, some of the “lessons learned” in our start-up years will be described as well as our future plans, including a greater focus on interprofessional education.
- 12:15 – 1:15 pm **Lunch**
- 1:15 – 4:00 pm **Best Practices Workshop**
This interactive workshop is a chance for Respiratory Therapy educators to break into smaller groups and discuss best practices in a variety of areas. Topics for discussion include Implementation of the National Competency Profile, Preceptorship training, Medical Simulation, Logbook design and use in the clinical setting, Performing and documenting clinical evaluation and more. Participants will be asked to share original or innovative teaching and evaluation tools.
- 6:00 – 9:00 PM **CSRT Wine and Cheese Reception —
Book Launch for CSRT History Book and Opening of Exhibits**
Location: Marco Polo Room

May 26, 2006 – friday

- 7:30 – 8:30 am **Exhibitors' Breakfast**
Location: Foyer and Spencer Rooms I, II & III
- 8:30 – 9:00 am **Opening Remarks**
Location: Loyalist Room
- 9:00 – 10:00 am **Keynote Speaker: Sean Swarmer** — *Sponsored by Canadian Intensive Care Foundation*
Sean isn't just a cancer survivor; he is truly a medical marvel. He is the only person in the world ever to have been diagnosed with both Hodgkin's Disease and Askin's Sarcoma. He was diagnosed in the fourth and final stage of Hodgkin's Disease at the young age of 13 when doctors expected him to live for no more than 3 months. A determined young man, he overcame his illness only to be stricken a second time when a deadly golf ball-sized tumor attacked his right lung. After removal of the Askin's tumor, Sean was expected to live for less than two weeks. Now, a decade later and with only partial use of his lungs, Sean is accomplishing things that most would never dream possible — including reaching the summit of Mount Everest. Hear his inspiring story — dream big and never give up.
- Presentation of the Summit Technology Award**
- 10:00 – 11:00 am **Ethics, Professional Behavior and Cultural Diversity in the Respiratory Therapy Profession**
Keynote Speaker: Carl Wieszalis, MS, RRT — Sponsored by Boehringer Ingelheim and Pfizer
The foundation for technical and clinical performance of the tasks and responsibilities collectively called “Respiratory Therapy” is most appropriately and effectively built upon a foundation of scientific truth and sensitivity to the needs and desires of the communities served by the profession. The practitioners of a profession are called “professionals” and medical professionals are expected to conduct themselves in a manner consistent with the historical and contemporary standards of the community. As most allied health specialists are directly derived



CSRT Educational Forum Programme

- 10:00 – 11:00 am from the concept of “physician”, the community expects respiratory therapists to practice philosophies, attitudes and behaviours consistent with codes of conduct elaborated by and for physicians over the centuries. The speaker will also weave concepts related to “diversity” into the theme of ethics and professional behaviour.
- 11:00 – 12:30 pm **Lunch with Exhibitors, Exhibit Hall**
Location: Foyer and Spencer Rooms I, II & III
- 12:30 – 1:30 pm **BREAKOUT SESSION 1**
- Module A**
Location: Montagu III
Neurally-Controlled Ventilation
Dr. Christer Sinderby, MSc, PhD
Neurally adjusted ventilatory assist (NAVA) is a mode of mechanical ventilation where positive pressure is instantaneously applied to the airway opening in proportion to the electrical activation of the diaphragm (EAdi) (Sinderby *et al*, 1999 Nature Medicine). The EAdi represents the patient’s respiratory drive. Hence, during NAVA, the ventilator support is synchronous with and proportional to the respiratory drive and therefore acts as an external “respiratory muscle pump”. The amount of assistance delivered by NAVA is determined by a proportionality factor determining the magnitude of pressure delivered for a given EAdi amplitude. Current studies in animals and adult patients show the feasibility of implementing NAVA clinically. NAVA offers synchronized assist in direct proportion to the needs of the patient, and due to its unique pneumatic-independency, is not affected by leaks. This opens up the possibility of delivering synchronized non-invasive mechanical ventilation. Besides the use of the diaphragm electrical activity to control the respirator, simply monitoring the EAdi can provide useful information about the effects of various treatments and interventions.
- Module B**
Location: Belleisle I
Neonates
Ann Hudson Mason
- Module C**
Location: Montagu I
Level III Sleep Studies
Dr. Glen Sullivan
- Module D**
Location: Montagu II
New Initiatives and Perspectives on COPD
Carl Wiezalis, MS, RRT — Sponsored by Boehringer Ingelheim and Pfizer
All Respiratory Therapists know that the prevalence of COPD has been increasing throughout the world in both developed and under-developed nations. The World Health Organization (WHO), together with the US Heart, Lung and Blood Institute, NIH, developed new guidelines for the diagnosis and care of individuals at risk for COPD which is rapidly moving into the fourth position as a leading cause of morbidity and mortality throughout the world. Over a hundred nations around the world, including Canada, have partnered with the WHO to advance the GOLD Guidelines. As a result of this initiative, a not-for-profit, patient-centered organization was formed to promote self-care and peer support for patients and families suffering from COPD.



CSRT Educational Forum Programme

12:30 – 1:30 pm This new organization called the National Emphysema/COPD Association (NECA) conducted the largest survey of COPD ever conducted in the United States. Six separate surveys were directed to pulmonologists, family practice physicians, three cohorts of COPD patients and respiratory therapists. This lecture will introduce this professional audience to NECA, a global association and reveal some of the important data derived from this complex survey process.

1:30 – 2:30 pm

BREAKOUT SESSION 2

Module A

Location: Montagu I

Pulmonary Arterial Hypertension: Care of the Child

Janette Reyes, RN, MN (ACNP)

It is difficult to imagine anything worse than a person being diagnosed with a rare, progressive and incurable illness. One can only admire the courage of a child who lives through the course of this disease. Understanding the pathophysiology and knowing the symptoms of pulmonary hypertension will provide a rationale for the multiple diagnostic tests necessary to isolate the diagnosis.

Although there is no cure for PAH, there are medical therapies available that can delay the progression of the disease and improve quality of life. Lung or heart/lung transplantation is the ultimate treatment option for end stage disease. Research investigations continue with the hope of conquering this dreadful disease.

Module B

Location: Montagu II

End-of-Life Care in Advanced Lung Disease — Addressing Unmet Needs

Dr. Robert Horton, MD CCFP Assistant Professor Department of Medicine, Division of Palliative Medicine, Dalhousie University, Halifax, Nova Scotia

Keywords: COPD, IDIOPATHIC PULMONARY FIBROSIS, LUNG DISEASE, END-OF-LIFE, PALLIATION

Introduction: Patients living with advanced COPD and Idiopathic Pulmonary Fibrosis have complex physical, emotional, and supportive care needs related to diminished quality of life associated with advancing chronic illness. Needs of patients with advanced lung disease equal or surpass those of patients with advanced lung cancer. Previous studies have demonstrated that patients with advanced lung disease have unmet needs related to poor control of symptoms, lack of information about their disease and treatment options and inadequate plans for care following hospital discharge. Increased access to palliative care services and improved communication regarding end-of-life issues for this patient population has been advocated, yet traditionally, palliative care programs have not routinely served these patients.

Objectives: Using a case based approach, issues relevant to providing palliative care to patients with advanced lung disease will be highlighted. The presentation will highlight challenges, barriers and opportunities in providing quality end-of-life care in patients living with advanced lung disease. A brief review of the current literature pertaining to palliative care in this patient population will be included. Participants will be encouraged to share their knowledge and experience.

Module C

Location: Montagu III

Steroid Resistant Asthma

Dr. Dennis Bowie



CSRT Educational Forum Programme

1:30 – 2:30 pm

Module D

Location: Belleisle I

Airway Olympics

Rick Paradis

The Airway Olympics require the respiratory therapists and anesthesia assistants to intubate in various difficult positions. It is a race against the clock and fellow RTs! You are expected to intubate in the normal routine position, prone, left lateral, right lateral, kneeling and icepick. Techniques are used in the real world settings and have been shown to respiratory therapists, paramedics, medical students and anesthesiologists. Penalties are applied to “teeth clicking” and leaving the laryngoscope “on”. Esophageal intubations mean that you have to keep trying until the tube is in place. Patients are considered dead if the intubation takes longer than 4 minutes. We are looking for 1 representative from the Maritimes, Quebec, Ontario and our Western provinces. Best overall average time is the winner and will receive a prize! To date, the best witnessed time is 7 seconds!

2:30 – 3:00 pm

Refreshment Break, Exhibit Hall

Location: Foyer and Spencer Rooms I, II & III

3:00 – 4:00 pm

BREAKOUT SESSION 3

Module A

Location: Montagu II

Ventilator Associated Pneumonia

Richard Milo

Ventilator Associated Pneumonia (VAP) is a pneumonia that develops 48 hours after intubation resulting in increased hospitalization with substantial costs to the healthcare system. The incidence of VAP ranges from 10 – 65% depending on the type of Intensive Care Unit (ICU). Patients that develop a VAP have an increased ICU length of stay by 4.3 days followed by an increased Ward length of stay by 3.8 days. This attributes to an increased cost of approximately \$30,000/VAP.

The Intensive Care Unit at Kelowna General Hospital has been recognized as a Canadian leader in the delivery of “Improving Patient Care and Patient Safety” for its part in the ICU Collaborative and reduction in VAP. Using seven best practice standards we have been able to reduce the rate of VAP by 50% in the past year. The result has many important implications such as reduced mortality and morbidity, reduced length of stay in ICU, reduced antibiotic costs and less development of antibiotic resistant infections and that results in substantial cost savings It also results in improved access to the ICU and overall better patient care.

Module B

Location: Montagu III

Shiftwork Sleep Syndrome

Sandra MacMaster, RRT

Module C

Location: Montagu I

RTs in Primary Care

Sue Ness, RN, MHS/Joanne Young, RRT

The management of chronic illness is costing billions of Canadian health care dollars per year, and it is recognized that a more comprehensive approach to improve outcomes for this population is imperative.



CSRT Educational Forum Programme

3:00 – 4:00 pm

It is well documented that patient/family education, access to an interdisciplinary team, and self-management techniques are key strategies that empower patients to feel in control of their chronic condition(s).

Reducing the frequency of exacerbations, minimizing distressing symptoms, and improving quality of life is both patient-focused and fiscally responsible. Access to appropriate resources and programming is also essential.

This presentation will discuss New Brunswick's proactive approach to community-based care and focus specifically on the role of Registered Respiratory Therapists as case managers within New Brunswick's Extra-Mural Program.

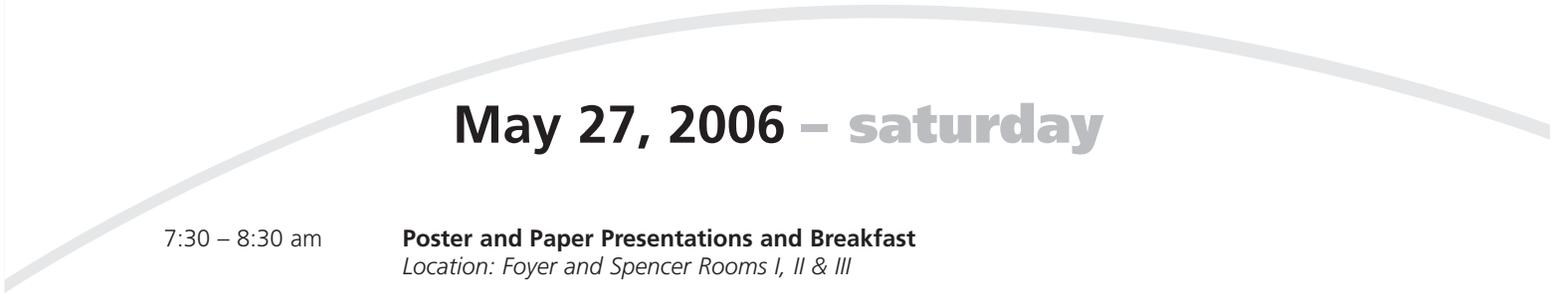
Module D

Location: Belleisle I

Anesthesia for Pediatric Bronchoscopy

Jeff Kobe

An overview of anesthetic techniques used for pediatric bronchoscopy, highlighting a case study of a two-year old pulmonary sling repair requiring emergency ECLS post aortic rupture during a rigid bronchoscopy.



May 27, 2006 – saturday

7:30 – 8:30 am

Poster and Paper Presentations and Breakfast

Location: Foyer and Spencer Rooms I, II & III

8:30 – 9:00 am

Opening Remarks

Location: Loyalist

Presentation of the Medigas Award

9:00 – 10:00 am

Keynote Speaker: Dr. Robert Kacmarek, PhD, RRT, FCCM, FCCP Management of ARDS: Beyond the ARDSnet Protocol

Both animal and patient literature has clearly established the need to reduce peak airway pressure and limit tidal volume. However, the animal data clearly indicates the need to avoid opening and closing of unstable lung units. The question of how to properly accomplish this aspect of a lung protective ventilatory strategy is still open to debate. Recent literature demonstrates that the lung can be opened by the use of recruitment maneuvers and the benefit of these maneuvers can be sustained if a decremental PEEP trial is used to identify the PEEP level avoiding derecruitment. Various strategies of identifying the optimal PEEP level will be discussed.

Presentation of the Trudell Awards

10:00 – 11:00 am

Keynote Speaker: Joe Lewarski, BS, RRT Long Term Care of the Tracheostomy Patient



CSRT Educational Forum Programme

11:00 – 12:30 pm **Lunch with the Exhibitors and Sputum Cup Challenge — “Respiratoranium”**
Location: Foyer and Spencer Rooms I, II & III

12:30 – 1:30 pm **BREAKOUT SESSION 1**

Module A

Location: Montagu III

PFT

Dr. Dennis Bowie

Module B

Location: Montagu II

Standards in Home Care

Joe Lewarski, BS, RRT

Module C

Location: Loyalist Room

Clinical Recognition Program

Dr. Robert Kacmarek, PhD, RRT, FCCM, FCCP

Few institutions have set up programs designed to recognize and reward clinical staff for performing at a level beyond that is expected of the experienced clinician. At the Massachusetts General Hospital we have a multidisciplinary program to recognize these individuals. Specific attributes of staff at all levels of practice have been defined and criteria for movement up the recognition later have been developed. Staff being considered for advancement must present a portfolio to a multidisciplinary board. This portfolio must establish that the clinician has met all criteria for the advanced level. In addition, the clinician must participate in an interview conducted by three members of the board. We have found that this program has greatly benefited individual staff as well as the department and has improved collaboration at the bedside.

Module D

Location: Montagu I

Benefits and Application of NO

Ann Hudson Mason

1:30 – 2:30 pm **BREAKOUT SESSION 2**

Module A

Location: Montagu I

Sedation During Mechanical Ventillation

Paul Ouellet — Sponsored by GE Healthcare

Module B

Location: Montagu II

Life/Work Balance: Finding Enough Time For Sleep

Dr. Rachel Morehouse — Sponsored by Fisher and Paykel Health care Inc.,

Module C

Location: Montagu III

Hemodynamics Made Easy

Dr. Tom Evans

Few bodily systems are as amenable to meaningful clinical assessment as the Cardiorespiratory system. Though at first glance “high tech” and intimidating, the relevance and clinical import of



CSRT Educational Forum Programme

1:30 – 2:30 pm easily available bedside cardiorespiratory data can be easily understood, even by the novice. The fundamental underpinning of such understanding is a knowledge of basic Cardiorespiratory and Autonomic Physiology. Dr. Evans will present that physiology in simple terms that should leave the student with an intuitive and sensible approach to hemodynamic data.

Module D

Location: Belleisle I

Critical Care

2:30 – 3:00 pm **Refreshment Break**

Location: Foyer

3:30 – 5:30 pm **CSRT ANNUAL GENERAL MEETING** — See page 23 for agenda

Location: Kennebecasis I & II

CSRT President's Awards and Banquet

Location: Marco Polo Room

6:00 pm — **Cocktails**
6:30 pm — **Dinner**
7:30 pm — **CSRT Awards**
8:00 pm — **Keynote Speaker — Mr. Arthur Black**
9:00 pm — **Dance** — "Boys Next Door"

Arthur Black — Keynote Address

The CSRT is pleased to announce that veteran CBC host Arthur Black will address delegates at the President's Banquet on May 27. For 19 years he hosted Basic Black, a national CBC radio program dedicated to wackiness. He currently hosts two television shows, *Weird Homes* (the winner of a Golden Globe and nominated for a Gemini) and *Weird Wheels*, both of which are self-explanatory. He also writes a weekly humour column syndicated in over 50 Canadian news papers and has authored eight books, including *Plaudits*, *Kudos* and *Huzzahs*. He has been awarded the Stephen Leacock Medal-Canada's highest award for humour, the National Magazine Award for Humour, an ACTRA "Nelly", Best Opinion/Commentary, Cadogan Award for Best Weekly Newspaper Column and Ohio State Award for Best Children's Series.

Banquet tickets can be purchased through Forum Registration Form or at the CSRT registration desk.

Sign up for the Sputum Cup Challenge — "Respiratoranium"!

Get a team of 4 together and sign up at the Registration Desk. You could win free registration to Forum 2007 in Montreal.

Saturday May 27, 11:30 am to 12:30 pm. Exhibit Hall. Based very loosely on the board game — Cranium.

You may have to hum a tune, dance a jig, whistle dixie, sketch an etching, sculpt a bust, act out or spell backwards to win. How talented is your team? **For more information call 1-800-267-3422.**



CSRT Educational Forum Programme

May 28, 2006 – **sunday**

8:30 – 9:30 am **Continental Breakfast**
Location: Loyalist Room

9:30 – 10:00 am **Opening Remarks**
Location: Loyalist Room

10:00 – 11:00 am **Ten Ways to Improve Your Success With NPPV**
Dr. Robert Kacmarek, PhD, RRT, FCCM, FCCP
The successful application of NPPV is dependent to a great extent on the capabilities of the clinician applying the technique. However, many institutions indicate limited success with NPPV. For this technique to be successfully applied the clinician must understand the indications, contraindications, and problems associated with NPPV. They must understand how to approach the patient to insure maximal success. They must know how to properly set the ventilator. They must understand the specific issues related to the individual ventilator used for NPPV. They must know how to select and fit a mask properly. They must know how to titrate O₂ into a bilevel pressure ventilator system. They must know how to deliver an aerosol treatment during NPPV. These individual factors can frequently be the difference between success and failure.

11:00 – 12:00 pm **Panel Discussion — Canadian RT Influences in Global Respiratory Therapy**
Respiratory Therapy has long been thought of as a North American domain with a few remote outposts in far away Saudi Arabia. Today however, increasing globalization has brought a growing appetite among developing countries for Western style healthcare. The Middle-East, the Pacific Rim nations, China and India are well on their way in creating an infrastructure for respiratory therapy. Lynn Beaton and Catherine Burke-Tremblay will highlight their experiences in China, while Lori Gordon and Dennis Hunter will discuss the development of educational programs in Qatar and Lebanon respectfully. The expert panel will review the influences that Canadian respiratory therapists have had in the world and discuss future opportunities.

- Lynn Beaton currently works for the Canadian Neonatal Network in Vancouver, British Columbia developing curriculum for respiratory therapists going to China.
- Catherine Burke-Tremblay is a respiratory therapist from London, Ontario who has traveled to China and other nations promoting respiratory therapy. She is a member of the American Association for Respiratory Care's Ambassador program.
- Lori Gordon is an Instructor with the College of the North Atlantic in St. John's, Newfoundland. She was the lead developer for the respiratory therapy program curriculum being taught in the College's newest campus in Qatar.
- Dennis Hunter is a Professor at Fanshawe College in London, Ontario. He has been working closely with the Makassed General Hospital in Beirut Lebanon to setup a respiratory therapy program in that country.

12:00 – 12:30 pm **Closing Remarks**

Registration Form



Roxon Pub Crawl

Friday, May 26, 2006

CSRT delegates are invited to join in the fun as we sample some of the Saint John night life. We will tour the following establishments, which have all waived their entry fees for us:

- Cougars Melvin's
- Grannan's O'Leary's

Please wear your Roxon pin as identification — found in your delegate bag, and join us at the boardwalk at 7:00 pm with finger foods and drinks at Cougars — generously sponsored by Roxon Medi-Tech. Delegates may also wander over to Grannans to enjoy drink specials and watch the sun set.

At 9:15 pm or so we continue to rock on with Roxon at Melvin's with live entertainment and more!

At about 10:45 pm we will go around the corner to O'Leary's to cap off the evening. You may choose where you wish to go after the "official tour" is over.

CSRT Banquet

Saturday, May 27, 2006

After dinner — get ready for a party! The President's Banquet will be a memorable night. Not only will we have CBC host Arthur Black as our keynote speaker, we will be kicking off our shoes and doing some dancing to the **Boys Next Door**.

Based out of Halifax, **Boys Next Door** is a high energy four-man Maritime Kitchen Party band. They feature folk rock, adult contemporary, several traditional favorites as well as a variety of original compositions. They start at 9:00 pm in the Marco Polo Room.

For a complete details — please refer to the CSRT website under Annual Meetings.

Thank You to Our Educational Sponsor



| | |
|---|---------------------------------|
| ■ Full Registration — Members 2006–2007 | |
| *Pre-registration | 325.00 <input type="checkbox"/> |
| After April 21, 2006 | 395.00 <input type="checkbox"/> |
| ■ Full Registration — Non-members | |
| *Pre-registration | 470.00 <input type="checkbox"/> |
| After April 21, 2006 | 540.00 <input type="checkbox"/> |
| ■ Full Registration — CSRT Student Members | |
| Student Members** | 50.00 <input type="checkbox"/> |
| ■ Full Registration — Non-CSRT Student Members | |
| *Pre-registration | 75.00 <input type="checkbox"/> |
| After April 21, 2006 | 100.00 <input type="checkbox"/> |
| ■ Daily Registration <input type="checkbox"/> Fri. <input type="checkbox"/> Sat. <input type="checkbox"/> Sun. | |
| Members | 150.00 <input type="checkbox"/> |
| Non-members | 185.00 <input type="checkbox"/> |
| Student Members** | 50.00 <input type="checkbox"/> |
| ■ Options | |
| President's Banquet | 50.00 <input type="checkbox"/> |
| Additional Exhibitor Representative | 150.00 <input type="checkbox"/> |

* **Pre-registration deadline April 21, 2006**

****Must be currently enrolled in a CSRT approved program to qualify for the student rate**

Registration includes Exhibitors Breakfast, Sunday Continental Breakfast, two lunches and breaks, Wine and Cheese Reception, all lectures and workshops, entry to Exhibit Hall. GST is included in the total #119220010 RT

Refunds: Refunds are subject to a \$50.00 administration fee.

NAME _____

CSRT FILE # _____

EMPLOYER _____

POSITION (TITLE) _____

YOUR ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

HOME TEL. _____ WORK TEL. _____

E-MAIL _____

METHOD OF PAYMENT

TOTAL PAYMENT \$ _____



CARD NUMBER _____ EXPIRY DATE _____

SIGNATURE _____

PRINT NAME _____

YES, I WILL BE ATTENDING THE FUN NIGHT.

Send to: CSRT 102 - 1785 Alta Vista Drive. Ottawa, Ontario K1G 3Y6
For more information please contact the CSRT at 1-800-267-3422 or (613) 731-3164 Fax: (613) 521-4314 E-mail: csrt@csrt.com



Exhibitor Directory

AirSep Corporation
Booth #36

AstraZeneca Canada Limited
Booth #52

**Bayer Incorporated —
Diagnostics**
Booth #9

**Benson Medical Industries
Incorporated**
Booth #18

**Boehringer Ingelheim
(Canada) Limited & Pfizer
Canada Incorporated**
Booth #48

BOMIMED Incorporated
Booths #45 & 46

**Canadian Intensive Care
Foundation**
Booth #7

Carestream Medical Limited
Booth #43

Cardinal Health
Booth #53

CSRT
Booth #50 & 51

**Draeger Medical Canada
Incorporated**
Booths # 5 & 6

**Fisher & Paykel Healthcare
Incorporated**
Booth #49

General Electric Healthcare
Booths #1, 2 & 3

**GlaxoSmithKline
Incorporated**
Booth #27

INO Therapeutics
Booth #55

**Instrumentation Laboratory
Canada Ltd.**
Booth #34

Invacare
Booth #44

Karl Storz Endoscopy
Booth #10

KEGO Healthcare
Booth #19

**Lifetronics Medical
Incorporated**
Booth #31

**Maquet-Dynamed Health
Care Systems**
Booths #21, 22 & 23

**McArthur Medial Sales
Incorporated**
Booth #16

**METI® Medical Education
Technologies Incorporated**
Booth #8

Nova BioMedical Canada
Booth #17

Pall Medical Canada Limited
Booth #57

Pentax Canada
Booth #29

**Professional Respiratory
Care Services**
Booth #39

**The New Brunswick
Pulmonary Hypertension
Society**
Booth #24

Radiometer Canada
Booth #4

**Respan Products
Incorporated**
Booth #15

**Respiratory Therapy
Specialists**
Booth #35

Resprionics Incorporated
Booth #54

Roxon Medi-Tech Limited
Booths #25 & 26

**Smiths Medical Canada
Limited**
Booth #56

Southmedic Incorporated
Booth #20

**Summit Technologies
Incorporated**
Booths #28, 37, 38 & 47

**Sunrise Medical Canada
Incorporated**
Booth #11

Trudell Medical International
Booth #12

**Trudell Medical Marketing
Limited**
Booth #30

Tyco Healthcare Canada
Booths #40, 41, 42

**VitalAire Canada
Incorporated**
Booths #32 & 33

Educator's Congress Registration Form

Thursday, May 25, 2006, 1:00 – 5:00 pm

Name: _____

CSRT File Number: _____

Employer: _____

Position/Title: _____

Address: _____

City: _____

Province: _____ Postal Code: _____

Home Telephone: _____

Business Telephone: _____

E-mail: _____

Method of Payment

Card Number _____

Expiry Date _____

Signature _____

Print Name _____

This registration does not include access to the CSRT Educational Forum 2006.

Send to:
CSRT 102-1795 Alta Vista Drive, Ottawa
ON K1G 3Y6
FAX: (613)521-4314

Registration Fees

CSRT member: \$90.00 Non-member: \$125.00

GST is included in the total #11922001ORT

Message from the President

I used to wonder what the CSRT President actually did. Well, now I know first-hand. Hopefully I can explain to you that which had been a mystery to me and perhaps to others as well.

During my last 10 months I have participated in all kinds of activities which will lead to an improvement in the profile of respiratory therapy. These activities include the regular duties expected of anyone in this position of which emails, phone calls, conference calls and meetings are all an integral part of communication. Other avenues in which I was involved include:

■ Participating in the adoption of the principles and framework of the Primary Health Care initiative, participating in the discussions surrounding health human resources and funding issues in primary care. From discussions with the chair of the primary care initiative, the CSRT subsequently joined a Health Action Lobby group, known as HEAL. This partnership may allow us to take advantage of federal funding available for special projects.

■ Advocacy has been a huge focus of the new board structure. Wrae Hill, Director of this portfolio has done a great job in providing support for CSRT members on issues such as the critical response teams popping up all over the country. We have also learned that supporting the province and working with the provincial association will net us a larger benefit when it comes to advocacy. I have partnered with the RTSO in their efforts to influence the Ontario Ministry of Health on the development and funding RT's in these critical care response teams. I believe we need to begin to anticipate the direction of health care and become proactive instead of reactive in the area of advocacy.

■ The CSRT is a member of the National Alliance for Respiratory Therapy as a defacto regulator for all

unregulated provinces. This group is now looking at the next re-iteration of the NCP and looking forward to the development of an exam process that meets the needs of everyone in the country for the current NCP. This is a work in progress and will be ever evolving. Doug Maynard is instrumental in this work on behalf of the CSRT.

■ The House of Delegates is a division of the CSRT, created to ensure the provinces have a voice that leads directly to the CSRT Board. This helps ensure that we work together provincially and nationally and not get into the territorialism which can happen knowing we are all focusing on the same group for membership. We are committed to having this group be the voice of the provinces and help shape the national initiatives for the future.

■ In the area of anaesthesia, we are creating a position statement regarding the CSRT's view of what an anaesthesia assistants role is and how the scope of practice relates directly to that of an RT. RT's are uniquely positioned to take on this role in some hospitals without further formal training, but with on-the-job training for added skills. Currently there is a link on the CSRT website for the Anaesthesia Special Interest Group providing more information.

■ Human Resources under the guidance of Sandra Biesheuvel, has provided the CSRT Board with nothing like they have ever seen before in this organization. We have policies, terms of reference and committee structure that is formalized. This will enhance the experience of future board members.



Sue Jones

■ There are other endeavors such as the recent membership survey which will help us form better services for our members; education and clinical standards which involves the development of the NCP; the treasurer's position which is being re-evaluated with the hope of adding onto the responsibilities of clinical practice guidelines developed. One of the areas our members have identified is the lack of a library of RT developed clinical practice guidelines.

Finally we have reviewed the strategic plan and all directors keep on track using a work plan that is reviewed and added to at each board meeting. This re-affirms the direction the CSRT is working towards and provides all of us with accountability knowing we must set goals and accomplish them within a set time frame. This was the brain child of Past-President, Brent Kitchen and I must say it keeps us all on track and focused.

I hope I have given you an idea of what the CSRT President's responsibilities and time commitments include. Also I forgot one thing, the president must submit reports to the journal on a routine basis and I have been politely reminded by the editor of the *CJRT* to again keep me focused.

Lastly, I have enjoyed my year as president and would encourage more of you to consider a future role as a board member for your association!

Sue Jones, RRT
CSRT President

Mot de la présidente

Par le passé, je me demandais ce que faisait exactement le(la) président(e) de la SCTR. Eh bien, je le sais très bien maintenant. J'aimerais tenter de vous expliquer ce qui était pour moi un mystère, et qui l'est peut-être encore pour certains d'entre vous.

Au cours des dix derniers mois, j'ai participé à une gamme d'activités qui ont eu pour effet de rehausser le profil de la thérapie respiratoire. Ces activités englobent les tâches régulières dont on s'attend de n'importe qui dans en pareil poste et où les courriels, appels téléphoniques, téléconférences et réunions constituent une composante essentielle de la communication.

J'ai été impliquée dans d'autres sphères, dont les suivantes :

■ J'ai participé à l'adoption des principes et du cadre liés à l'Initiative en soins de santé primaires, aux discussions liées aux ressources humaines en santé et aux questions de financement aux soins primaires. Suite aux discussions avec le président de l'Initiative en soins de santé primaires, la SCTR s'est jointe au Groupe d'intervention action santé, connu sous l'acronyme HEAL. Il se peut que ce partenariat nous permette de profiter d'un financement fédéral qui est disponible pour les projets spéciaux.

■ La défense des intérêts constitue un important point de mire pour la nouvelle structure du Conseil. M. Wrae Hill, directeur de ce dossier, a effectué un superbe travail vis-à-vis du soutien accordé aux membres de la SCTR sur des sujets tels les équipes d'intervention critique qui voient le jour partout au pays. Nous avons appris qu'il nous est possible de tirer davantage profit de la défense des intérêts si nous soutenons la province et travaillons avec l'association provinciale. J'ai conclu un partenariat avec la Société de la thérapie respiratoire de l'Ontario afin de soutenir ses efforts visant à influencer le ministère de la Santé de l'Ontario

au sujet du perfectionnement et du financement des TR au sein de ces équipes d'intervention critique. Je suis d'avis que nous devons anticiper la direction que prendront les soins de santé afin d'agir de façon proactive plutôt que réactive en matière de défense des intérêts.

■ La SCTR est membre de l'Alliance nationale de la thérapie respiratoire à titre d'organe de réglementation de fait pour toutes les provinces non réglementées. Ce groupe se penche maintenant sur la réitération du Profil national des compétences (PNC) et se réjouit à la perspective de l'élaboration d'un processus d'examen qui comble les besoins de tous et chacun au pays en ce qui concerne le PNC actuel. Il s'agit d'une œuvre en cours qui continuera d'évoluer. Le travail de M. Doug Maynard au nom de la SCTR est primordial à ce chapitre.

■ La Chambre des délégués est une division de la SCTR, créée afin d'assurer que les provinces aient une voix directe au Conseil de la SCTR. Elle permet d'assurer que nous travaillons ensemble à l'échelle provinciale et nationale plutôt que de nous embourber dans la territorialité qui peut se manifester lorsque nous misons tous sur le même groupe aux fins de l'adhésion. Nous sommes engagés à faire de ce groupe la voix des provinces, laquelle pourra modeler les initiatives nationales à l'avenir.

■ Au chapitre de l'anesthésie, nous rédigeons une déclaration qui précise la perception de la SCTR à l'égard de ce qui constitue le rôle des adjoints en anesthésie et la façon dont le champ d'exercice est directement lié à celui d'un TR. Les TR se trouvent dans l'unique position d'assumer ce rôle dans certains hôpitaux sans formation formelle additionnelle, mais plutôt avec une formation en milieu de travail visant à perfectionner les habiletés. Des détails additionnels sont publiés par le Groupe d'intérêt des adjoints en anesthésie par le biais d'un lien sur le site Web de la SCTR.

■ Les Ressources humaines, sous la direction de Mme Sandra Biesheuvel, ont fourni au Conseil de la SCTR des outils non disponibles jusqu'ici, soient des politiques, mandats et structures de comités formels qui rehausseront l'expérience des futurs membres du Conseil.

■ Nous travaillons également à d'autres initiatives, tel le récent sondage auprès des membres, qui nous permettra de concevoir de meilleurs services pour nos membres; l'éducation et les normes cliniques qui sont liées à l'élaboration du PNC; la réévaluation du poste de trésorier dans l'optique d'y ajouter la responsabilité des directives de pratique clinique. Un de nos membres a identifié l'absence d'une bibliothèque de directives de pratique clinique élaborées par les TR.

Nous avons également révisé le plan stratégique. Tous les directeurs sont dans la bonne voie grâce au plan de travail qui est révisé et mis à jour à chaque réunion du Conseil. Cette pratique réaffirme la direction dans laquelle la SCTR est engagée et nous responsabilise, puisque nous devons établir des buts et les atteindre dans un délai préétabli. Il s'agit d'une idée de notre ancien président, M. Brent Kitchen, et je dois avouer qu'elle nous tient sur la bonne voie et nous permet de rester fixés aux buts.

J'espère vous avoir donné une idée des responsabilités et des engagements du poste de la présidence. J'oubliais de préciser que le président doit systématiquement soumettre des rapports au journal, tâche dont la rédactrice en chef de la *RCRTR* doit me rappeler poliment de temps à autre.

J'ai beaucoup apprécié mon année à titre de présidente et je vous encourage tous et chacun à songer à occuper un poste à titre de membre du Conseil de votre association!

Sue Jones, TRA
Présidente de la SCTR

Notice of Annual General Meeting

Notice is now given that the Annual General Meeting of members of the Canadian Society of Respiratory Therapists/ La Société Canadienne des Thérapeutes Respiratoires (the "Society") will be held at the:

The Saint John Trade and Convention Centre
Loyalist Room
One Market Square
Saint John NB
May 27, 2006
3:30 – 5:30 pm

For the following purposes:

- a) to receive, and if thought fit, to adopt the reports of the Directors, the audited financial statement of the Society for the year ended March 31 2006, together with the report of the Auditors thereon;
- b) to appoint auditors and to authorize the directors to fix remuneration;
- c) to conduct other business of the Society.

Current Registers/Honourary Members of the Society, who are Registered Respiratory Therapists, in good standing, are entitled to vote at meetings by appointment of Proxy.

ALL MEMBERS WHO ARE UNABLE TO ATTEND THE MEETING IN PERSON ARE REQUESTED TO OBTAIN, COMPLETE AND RETURN A PROXY FORM TO THE EXECUTIVE DIRECTOR OF THE SOCIETY, 102-1785 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA, K1G 3Y6.

PROXY FORMS ARE AVAILABLE FROM THE CSRT OFFICE (1-800-267-3422) OR THE CSRT WEBSITE (www.csrt.com).

Dated at Ottawa, Ontario,
March 30, 2006
By order of the CSRT Board of Directors.

Douglas Maynard, RRT, MBA
Executive Director, CSRT



Canadian Society of Respiratory Therapists Board of Directors 2005–2006

EXECUTIVE OF SOCIETY

President

Sue Jones, RRT
(Ontario)

Treasurer

Kevin de Jong, RRT
(Ontario)

President Elect

Rob Leathley, RRT
(New Brunswick)

Executive Director

Doug Maynard, RRT
(Ontario)

Past President

Brent Kitchen, RRT
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Colya Kaminiarz, RRT
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Director of Human Resources

Sandra Biesheuvel, RRT
(Manitoba)

**Director of Professional
Advocacy**

Wrae Hill, RRT
(Alberta)

**Director of Education and
Clinical Standards**

Ray Hubble, RRT
(New Brunswick)

**Director of National
Provincial Relations**

Scott LeMessurier, RRT
(Newfoundland)

CSRT AGM Agenda 2006

May 27, 2006 at 3:30 pm
Saint John Convention Centre
Loyalist Room
Saint John, NB

Agenda

1. Welcome and Call to Order
2. Confirmation of quorum, scrutineers and parliamentarian
3. Introductions
4. Approval of Agenda
5. Approval of Minutes of the CSRT 2005 Annual General Meeting
6. Executive Reports
 - 6.1 President's Report
 - 6.2 Treasurer's Report
 - 6.3 Appointment of Auditor
 - 6.4 2006 Budget
 - 6.5 Annual Report
7. Election of Officers
8. New Business
 - 8.1 CSRT Board of Directors Structure
 - 8.2 Neonatal/Pediatric Special Interest Group
 - 8.3 Fee Increase
9. Other Business
10. Adjournment

**CSRT Educational Forum 2007
Montréal, Québec**

May 31 – June 3, 2007



On-Line Forum Registration

In our continuing commitment to offer our members the services they wish to receive, the CSRT is now offering on-line registration for the CSRT Educational Forum and Educator's Congress, as well as registration for membership renewals.

There are some limitations to membership renewal with regard to liability insurance.

Visit our website at
www.csrt.com

Rules of AGM Participation

The Annual General Meeting of the Canadian Society of Respiratory Therapists is an opportunity for members to debate current policy and issues. We encourage members to participate. To help members prepare for the meeting, we offer the following guidelines. Please feel free to address the Chair during the AGM to ask for clarification on issues. If you are unsure, chances are that others are as well.

Effective Participation

- Arrive on time.
- Read materials distributed before the AGM and ask questions about it beforehand.
- Any member can speak at an AGM. Approach the microphone and once the Chair has recognized you, identify yourself and raise your points.
- If you have an item to add to the agenda, or an objection to an agenda item, raise it when the Chair asks if there are any amendments to the agenda. Do not wait for the "Other Business" portion of the agenda.
- A member wishing to enter discussion on a motion may only do so when recognized by the Chair.
- A member speaks to the motion and addresses the Chair. If you disagree, disagree with ideas and motions, not people. Begin your

comments with "Madame/Mr. Chairperson, I speak in favour of (or against) the motion, because..."

- Remarks are "out of order" when they do not speak to the motion.
- Do not second a motion just to enable discussion. This delays the meeting and can be frustrating to those in attendance.
- A "motion to table" puts a motion on the books for an indefinite period of time and renders it non-debatable. When you want a motion postponed until a specific date, it becomes a simple motion that is fully debatable.
- A member may "call the question", meaning they are asking that the vote be called. Other members may request that the debate continue after a member makes this request. It is the Chair who accepts or denies the request to call the question. Members must then accept the ruling or challenge the Chair.
- When a member sincerely believes the Chair's decision or ruling constitutes an error in principle, the member may interrupt the Chair by saying "I appeal the decision of the Chair" and then briefly and politely state why. If the appeal is not seconded, the matter ends and the Chair's decision stands.

Proxy Notice

If you are unable to attend the CSRT Annual General Meeting in Saint John, please exercise your right to vote and be heard, by appointing someone who will be in attendance, to vote your behalf. The results of voting on motions are determined by the members in attendance, along with the proxies held by voting members in attendance.

If you are a voting member of the CSRT you should have received a Proxy form in the mail. You may complete this proxy form and have a member who will be in attendance, register your vote on all matters. Canada Post regulations prohibit the CSRT from including a proxy form in this journal.

You may obtain a proxy form from the CSRT website (www.csrt.com) or from the CSRT office through email at csrt@csrt.com or by phone 1-800-267-3422 or by fax at (613) 521-4314.

Your signed proxy must be filed with the CSRT Executive Director no later than 24 hours before the scheduled start of the Annual General Meeting of the Canadian Society of Respiratory Therapists/ La Société Canadienne des Thérapeutes Respiratoires (May 26, 2006 at 3:30). It can be faxed to (613) 521-4314.

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Canadian Public Health Association
In Partnership with the National Health Association
613-725-3769 x153
nlhp@cpaha.ca
www.cplsa.cpha.ca



Looking Ahead

Michelle Kowlessar, Accreditation and Education Manager

The Council on Accreditation for Respiratory Therapy Education (CoARTE) is looking ahead by planning to enhance the accreditation program and its internal and external policies. CoARTE is taking a proactive approach to the new changes arising in the respiratory therapy profession that will result from the upcoming implementation of the National Competency Profile in September 2006. The complete integration of the new profile promises the development of more effective entry-level respiratory therapist graduates in the profession.

As a first step, Council members have revised the CoARTE Governance document and plan to replace it with Terms of Reference and Rules of Procedures. These will provide more detailed information to aid our CSRT Volunteers, who serve as Council members, in leading our educational evolution. The new Terms of References will be considered for ratification by the CSRT Board of Directors at their Annual Meeting in May 2006.

In consultation with our clients and stakeholders, the Accreditation Handbook will be extensively revised and updated so that it is more informative and user-friendly.

CoARTE wishes to improve the program so that each accreditation visit can continue to be a positive experience for all respiratory therapy programs in Canada.

CoARTE is also developing a comprehensive Program Reviewer Handbook to train and assist our senior administrators, physicians and respiratory therapists who generously volunteer their time and expertise to conduct accreditation reviews.

As we move ahead, relationships between our clients and stakeholders will take on even more importance than ever before. CoARTE appreciates the commitment that all schools and stakeholders have made to the national accreditation program and hopes everyone will continue to be active participants in its evolution. Everybody benefits when all stakeholders work together in the interest of high quality education and safe patient care.

CoARTE's Mission and Vision

Mission

The mission of CoARTE is to promote the highest quality of respiratory therapy education through accreditation services.

Vision

CoARTE endeavors to provide accreditation services characterized by:

- Customer Focused by being Supportive, Collaborative, Instructive and Transparent
- Competency-Based Analysis and Evaluation
- National Recognition of Quality
- Efficiency and Cost-Effectiveness
- Quality Promotion through Sharing of Best-Practices

Upcoming Site Visits

University of Manitoba

March 11–14, 2007
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A Practice Review of 52 Cormack Grade 4 Direct Laryngoscopies

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Introduction: We undertook a retrospective chart and database audit of 24 months' practice at a teaching institution to review incidence and outcomes of Grade 4 laryngoscopies (G4L).

Methods: Following ethics board approval; the computerized anesthetic record database was queried for all possible references to 'airway' from Jan 2002 to December 2003. Resultant records were hand-searched for any reference to G4L. When identified, the patient's paper chart and electronic anesthetic record were reviewed.

Results: During the 2-year period, 17800 general anesthetics requiring intubation were performed. 52 G4Ls were recorded, for an incidence of 2/1000. 63% of the G4Ls were obtained by 11% of the department membership. Difficult intubation was anticipated in 71% of cases. Of these anticipated difficult cases, an intermediate-acting non-depolarizing muscle relaxant (NDMR) was used in 64% of cases and succinylcholine in only 36%. All except two cases were successfully intubated: one case was awoken and one had surgery proceed with an LMA. In only two cases was difficulty with bag-mask ventilation (BMV) noted (both were rescued with LMA) although specific note of ease of BMV was made in only 43% of records. Only 2 patients suffered oxygen desaturation to < 90% (to nadirs of 85 and 88%) prior to intubation; no patient required an emergent surgical airway and none had their surgery cancelled. Adjunctive or alternative maneuvers or equipment used in response to the G4L appear in Table 1, with effectiveness.

Discussion: Total incidence of G4L, at 0.018%, was in keeping with previous reports.^{1,2} A high percentage of clinicians elected to use a NDMR in the face of anticipated difficult laryngoscopy, possibly representing a shift in practice over the traditional use of succinylcholine. Lightwand use resulted in a high success rate. Bougie use was unimpressive. We conclude that encountering a G4L does not necessarily lead to patient morbidity or cancellation of surgery.

Paediatric Deadspace Affects on RR and PIP Not Predicted by ET_{CO}₂

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Background: Filters are increasingly used in breathing circuits as they protect the circuit from contamination and facilitate humidification of inspired gas. The use of filters, however, can augment the anatomical deadspace. This can be significant in children because they have much smaller tidal volumes.

Methods: Following institutional ethical approval, 20 healthy children less than two years of age who required endotracheal intubation were recruited. Ventilation was adjusted to achieve an end-tidal partial pressure of carbon dioxide (PETCO₂) of 35 mmHg when sampled at the endotracheal tube (ETT) adapter. Following a 10 minute period of stabilization, an airway filter (22 ml) was introduced into the circuit. The respiratory rate (RR) was then adjusted to return PETCO₂ to 35 mmHg.

Results: A mean increase in ventilation of 1.42(0.38) L×min⁻¹ was required to maintain a normal PETCO₂ level. Airway pressure and respiratory rate increased by 7.9(4.6) mmHg and 19.8(8.7) breaths/min, respectively. The PETCO₂

and partial pressure of inspired carbon dioxide (PiCO₂) measured from the ETT adapter were higher than measured from the filter port. The mean increase was 3.6(1.6) mmHg for PETCO₂ and 5.9(3.9) mmHg for PiCO₂.

Conclusion: Amplified deadspace due to airway filters results in a significant increase in ventilation needed to maintain a normal PETCO₂ in children less than two years of age with normal lungs. Sampling of PETCO₂ and PiCO₂ from the filter significantly underestimates the effect of increased deadspace. The effect of increased deadspace may be predicted using a proposed mathematical model.

Clinician's Confidence in the Efficacy of a New Oxygen Therapy Delivery Device

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Background: A new open oxygen delivery device, the OxyArm, manufactured by Southmedic Inc., Barrie, Ontario, Canada, was launched in 2000. It uses a unique diffuser device mounted on an adjustable arm that is positioned close to the patient's oral/nasal area. Laboratory and clinical testing have displayed oxygen delivery efficiency to be comparable to conventional oxygen delivery devices. The OxyMask and OxyChin brought out in 2004 use the same diffuser technology with different acute patient interfaces.

Purpose: A trial of the new products for a two month period in the acute areas of a 300 bed community hospital was conducted from January 2005–March 2005 to determine how clinicians perceived efficiency of oxygen delivery and clinical value of the devices.

Method: OxyMasks and OxyChins were used by clinical staff for a period of two months. A survey was administered to users. Two focus group meetings were held post trial to collect more surveys and comments.

Results: Forty two questionnaire responses from clinicians were collected. They reported using one or more of the products. 73.8%(31) reported easy application, 92.8%(39) felt the patient was adequately oxygenated by the

Table 1. Response to G4L. with Results

| Maneuver used | # patients in whom maneuver or device tried | If used, successful in # |
|---------------|---|--------------------------|
| 'BURP' | 9 | 1 (11%) |
| Stylettet ETT | 13 | 7(54%) |
| Bougie | 15 | 7 (47%) |
| Trachlight™ | 33 | 28(85%) |
| Flexible FOB | 9 | 7 (78%) |

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devices. 61.9%(26) said they would use the OxyMasks if available, 21.4%(9) would not. 42.8%(18) reported they would use the OxyChins if available, 33.3%(14) would not.

Many comments and suggestions were collected, some of which prompted design changes for more effective clinical application.

The results display most clinicians were confident that the product delivered oxygen appropriately to patients and would use the products again.

A Valved Holding Chamber (VHC) Manufactured from Electrostatic Charge Dissipative Materials is More Effective Than Non-Conducting VHCs Used Out of the Package

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Purpose: Manufacturers advise pre-washing VHCs with detergent to mitigate electrostatic charge that reduces medication delivery from pressurized metered-dose inhalers. These instructions may not be followed in the ER where time-to-treat is critical, or in pulmonary function laboratories (time restrictions). We report a study in which the delivery of a beta-2 agonist (Ventolin®-HFA, GSK plc, 100-µg/actuation salbutamol base equivalent ex metering valve) via a new VHC (AeroChamber® HOSPITAL Anti-static, Trudell Medical International) was compared with non-conducting VHCs (ProChamber™, OptiChamber® Advantage, both Respironics Inc., SpaceChamber™, PARI Respiratory Equipment Inc., Pocket Chamber™, Ferraris Medical Inc.) evaluated directly from their packaging.

Methods: Fine particle mass (FPM) < 4.0 µm aerodynamic diameter was determined using a Next Generation Pharmaceutical Impactor (n=3 devices/group) at 30.0 L/min, following the procedure in Canadian Standard CAN/CSA/Z264.1-02:2002. The onset of sampling was delayed for 2-s following pMDI actuation to simulate use by the poorly coordinated patient.

Results: FPM2-s delay/actuation (mean ± SD) ex AeroChamber® HOSPITAL VHC was 27.3 ± 2.2 µg, compared with 2.1 ± 2.0 µg (ProChamber™), 3.5 ± 0.7 µg

(OptiChamber® Advantage), 3.5 ± 0.4 µg (SpaceChamber™) and 2.7 ± 0.6 µg (Pocket Chamber™).

Conclusion: Clinicians should be aware of the dosing implications from these data when prescribing VHCs, especially where there is the likelihood that pre-washing will not be performed.

Improved Performance from a Valved Holding Chamber (VHC) Manufactured from Electrostatic Charge Dissipative Materials Compared With a Cardboard VHC

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Purpose: VHCs are prescribed for patients whose pressurized metered-dose inhaler technique is poor to the point at which actuation takes place upon exhalation, rather than on inhalation. A Canadian Standard (CSA/Z264.1-02:2002) therefore advocates laboratory testing of VHCs by breathing simulator, to determine emitted mass when actuation coincides with the onset of inhalation (EMcoordinated) and exhalation (EMuncoordinated).

Methods: We determined EM in accordance with this Standard using a beta-2 agonist (Ventolin®-HFA, GSK, plc 100-µg/actuation salbutamol base equivalent ex metering valve) via a new VHC (AeroChamber® HOSPITAL Anti-static, Trudell Medical International (AC-H)). Comparative measurements were made with a cardboard VHC (LiteAire®, Thayer Medical Corp. (LITE)). Each VHC (n=5/group) was connected to a breathing simulator operating with an adult respiratory pattern (tidal volume = 770-ml, 12 breaths/min, inspiratory/expiratory ratio = 1:2). The delay when inhaler actuation took place at the onset of exhalation was approximately 1.7-s.

Results: EMcoordinated (mean ± SD) was 52.4 ± 8.1 µg (AC-H) and 27.0 ± 2.7 µg (LITE). EMuncoordinated was 30.8 ± 3.1 µg (AC-H) and 3.1 ± 1.6 µg (LITE). A decrease with uncoordinated use is normal and associated with particle settling within the VHC, however the large decrease associated with the LiteAire® could be indicative of leakage.

Conclusion: Clinicians should be aware of the dosing implications from these data when prescribing VHCs.

Evaluation of Three Devices and One Technique for Pulmonary Drainage in a CF Patient

Norman Tiffin RRT, Summer Petras

Introduction: We evaluated three devices: the Pari PEP™ (Pari Respiratory Equipment, Midlothian, VA), the Acapella™ (Smith Medical, St. Paul, MN), the Vest Airway Clearance System (Hill-Rom, St. Paul, MN), and postural drainage in a stable 39 year old patient with cystic fibrosis to determine if there were differences in sputum production and patient preference.

Method: Over 33 contiguous days sputum was collected at the same time each day after the same aerosol treatment (albuterol) was taken. The four modalities were changed daily in a repeating pattern and sputum was collected and measured by mass and volume daily wet, then dried by a food dehydrator (Nesco/American Harvest, Two Rivers, WI) and re-weighed. The patient experienced no colds, infections or exacerbations during the trial that would affect sputum production and her FEV₁ was unchanged. Mass and volumes for each modality were compared using repeated measures ANOVA with post hoc Fisher LSD using an alpha value of 0.05.

Results: Figure one shows wet and dry mass and wet volume daily sputum averages. In all measures the PEP and Acapella produced significantly more sputum (p<0.01) than either the vest or postural drainage. The vest and postural drainage did not yield statistically significant differences in sputum production using any measure. The patient preferred the Pari PEP because of its portability and time saving during aerosol therapy.

Conclusion: The devices that produce positive expiratory pressure, ie. PariPEP and acapella, yield greater sputum production than either postural drainage or the vest clearance system. The Pari PEP device was preferred by the patient.

The Performance of a Novel Humidification Device for Mechanical Ventilation

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Rationale: To determine the effectiveness of a novel humidification device

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(Hydrate, Pari Respiratory Equipment, Midlothian, VA) during mechanical ventilation to provide adequate humidity and heat of inspired, dry gas flow.

Method: We used a Puritan Bennett 7200 mechanical ventilator with a rate of 15 bpm, $V_t=700$ mL, PEEP=10 cm H₂O and descending waveform setting. Our test lung (Quick Lung, Ingmar Medical, Pittsburg, PA, USA) was set to normal lung settings to simulate $C_p=0.2$ L/cm H₂O and $R_a=5$ cm H₂O/L/s. The device was inserted into the ventilator circuit 6 proximal to the patient wye. Heat and relative humidity (RH) were recorded at the patient wye every second for 30 minutes using an electronic thermometer and hygrometer. Time zero was at power on for the device. The source gas was dry oxygen; measured at 3% RH and 20°C.

Results: Average RH after 5 minutes was 84.5 + 8.1% and after 20 minutes was 90.1 + 2.8%. (average + stand deviation). Average temperature over the span of testing was 37.3 + 0.6°C with a maximum of 38.7°C. The inspiratory line of the circuit remained dry from the ventilator to the distal outlet of the device. No water was found on 6 tube from the device to the wye.

Conclusions: The device effectively heats the ventilator gas to within a narrow and clinically safe range of temperature and can humidify dry oxygen during mechanical ventilation to over 90% RH at the patient wye without the use of heated wires and keeping the inspiratory line of the circuit dry.

The Relationship Between a Final Examination and Two Formative OSCES Used in the Assessment of a College Respiratory Therapy Course

By Cary Ward, Canadore College, North Bay, ON

Purpose: The study examines the correlation between two OSCES given during the Respiratory Therapy Procedures course and the final examination. Understanding this relationship allows for improved methods for the evaluation of knowledge and clinical skills taught. The students' attitude to the process was investigated using a post evaluation questionnaire.

Methods: Thirty-six first year student took part in the study. One OSCE was given half way through the semester,

and the other was given at the end. The tested material on each reflected what was taught during that part of the course. Immediately after the last OSCE, the students answered an anonymous questionnaire and were provided space to make positive and negative comments. The final didactic examination in the course consisted of multiple-choice and short answer questions. The relationship between the OSCEs and the final examination and the descriptive statistics were examined.

Results: The correlation between the final didactic examination and the two OSCEs yielded a modest Pearson correlation coefficient ($p=.01$) of .570. The

average mark on each exam was 70%. The questionnaire was rated from 5 (strongly agree) to 1 (strongly disagree). The results were (see table below):

Conclusions and Implications:

Students' comments reflect their attitude toward this exam when stating that the OSCE provides a learning experience for evaluating weaknesses, gaining knowledge and practical skills. The OSCE can be used to evaluate and enhance course curriculum. Courses that incorporate teaching of clinical skills should consider incorporation of an OSCE to provide a more thorough evaluation of the students.

| Question | Mean | Standard Deviation |
|--|------|--------------------|
| The OSCE content matches that learned in the course | 4.75 | .500 |
| I would recommend continuing with this type of exam | 4.67 | .717 |
| The practical tasks reflect those taught in the course | 4.58 | .554 |
| The OSCE was useful for my learning | 4.53 | .654 |
| The OSCE was fair | 4.42 | .604 |
| There was enough time at each station | 4.03 | .971 |

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