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Cover Photo — Mary Bayliss

Front row — Left to Right
Karen Kennedy, Dean of Health Sciences CAN - NL; Pam Hicks, CoARTE Accreditation and Education Coordinator; Lynn Daley, Clinical Instructor; Christine Bolar, Chair of Health Sciences; Mary Parrott, Instructional Coordinator

Back Row — Left to Right
Mary Bayliss, Manager, Policy and Investigations; Linda Doody, Dean of Health Sciences CNAQ; Noel Pendergast, RT Instructor; Ray Hubble, President-Elect CSRT

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About This Issue

The fall is always a busy time for the CSRT Board and Staff. Numerous meetings, including the annual meeting of the Board of Directors, the National Alliance of Respiratory Therapy Regulatory Bodies (NARTRB) and CoARTE have taken place in the last few months.

Fall also brings the AARC annual conference, and the meeting of the International Council of Respiratory Care. The CSRT President, and myself, as Governor for Canada and Council Treasurer, attend this meeting.

This will be a big year for the CSRT at this meeting, as we will be reporting on our activities with the NARTRB on foreign credential recognition, and will also provide a report from the CSRT’s task force on international accreditation. More information on the activities of the task force, including a report from their recent trip to Qatar, are included in this issue.

The Winter issue gives us our first opportunity to provide some preliminary highlights of the upcoming national conference in Saskatoon, SK. Start making plans now to attend this “can’t miss” event.

There are some great articles including part two of a submission on intubation positions from our own airway olympian, Rick Paradis. Who better to write on this topic, after seeing the paces he puts the contestants through in the Airway Olympics? Any one who wants an advantage at the upcoming Airway Olympics competition in Saskatoon should pay special attention to this one.

We have also provided a report on the results of the CSRT Annual General Meeting, held in Montreal, this past October. One of the events at this meeting is the changing of officers. This meeting saw us welcome Ray Hubble, Saint John, NB and Jeff Dmytrovitch, Saskatoon, SK. We also bid farewell to Scott Lemessurier of Grand Falls-Windsor, NL. Scott came onto the Board in 2004, as one of the original members of the new Board of Directors structure. Scott was a great contributor on the Board, providing excellent analysis of the issues, and his opinion always, for me, acted as a litmus test for reasonable, sober thought. Scott will be missed, and we hope he continues to contribute to the CSRT and his profession in any way he can. Thank you for your time and all your contributions, Scott.

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

Dans ce numéro

L’automne est toujours une période fort occupée pour le Conseil d’administration et le personnel de la CSCT. Au cours des derniers mois, de nombreuses réunions ont eu lieu, y compris la réunion annuelle du Conseil d’administration et les réunions de l’Alliance nationale des organismes de réglementation en thérapie respiratoire (ANORT) et du CAFTR.
Advocacy Committee Reports On RT Week

Lisa Butcher RRT, CSRT Board of Directors Advocacy Chair, CSRT Advocacy Committee
Christina Beaudin RRT, CSRT Advocacy Committee, Public Awareness Champion

This year, the Advocacy Committee had great success with RT Week. Through the e-newsletter, the CJRT and a link on the CSRT website, it was easier than ever to be involved.

We secured excellent public venues, assisted in planning activities and coordinated with the CSRT head office for the dissemination of t-shirts, pens, pencils, banners and lots of brochures and literature. This year also celebrated the release of an ‘RT Week Radio Commercial’ in collaboration with the BCSRT. We had interest in several major cities and hope to bring it nation-wide next year.

Now that RT week is behind us and we have taken a short rest, it is important that we start thinking about activities for next year. Why not contact your local radio station or television station about RT week? Maybe they could come and talk about your display or learn about ventilators and pigs lungs? Since chronic disease management is a hot topic right now, tables set up with information on COPD and smoking cessation would be a great way to engage your community. It not only targets the general public but maybe even a co-worker who is interested in more information!

The CSRT often gets requests for assistance in setting up displays and demonstrations at provincial science centres, museums and other locations. Many of these types of demonstrations require many months of preparation, so remember: IT’S NEVER TOO EARLY TO START!

RT Week is a great opportunity to educate and promote our profession with those around us. Whether it’s through a booth at the local mall, a display at a stadium/arena or getting in touch with local media outlets — our goal is to teach the public about the importance of what we do. The Advocacy Committee is here to assist you in your future endeavors. Feel free to contact the committee if you want ideas for locations, ideas for potential activities, for suggestions on how to get your colleagues involved, or to just bounce your ideas around. We can be reached via email at rtweek@csrt.com or the CSRT office at 1-800-267-3422 for more information on how YOU can get involved!
Colin E. Lyon — In Memoriam

It is with great sadness to inform you of Colin Lyon’s passing on September 28, 2007 at the age of 62. Colin was a respiratory therapist in Halifax, NS, originally from the Windsor area in the Annapolis Valley. He held CSRT Registry Number 133.

Colin graduated from the first class of the School of Inhalation Therapy, Victoria General Hospital, Halifax in 1966 and continued on with the hospital department for 12 years in staff and management roles.

In 1978 he joined the IWK Children’s Hospital as staff RT and later in 1990 as our Technical Support RT where he remained until his retirement in 2005.

Colin had an innate ability for innovation, fixing and troubleshooting. Most would say that he was the original “duct tape guy” often masterminding new devices or improving the old with lightening speed, precision and accuracy. As such, Colin’s style has helped influence and mentor generations of respiratory therapists and to solidify respiratory therapy professionals as respected health care service providers today.

As talented as Colin was as a respiratory therapist his real gift was how to make people smile. He always had either a kind word or something, usually a gadget to make you laugh. Colin loved to spend time with family and friends, traveling, gardening and preparing for all the holidays, especially Christmas, his most favorite of all.

National Non-Smoking Week
Semaine nationale sans fumée

January 20–26, 2008 / Du 20 au 26 janvier 2008

The activities that take place during National Non-Smoking Week are as varied as the individuals and agencies that participate in the program. National Non-Smoking Week involves agencies and individuals working at the federal, provincial/territorial, regional and local levels. Thousands of people from coast-to-coast participate in the campaign, including local health units, local and provincial/territorial councils on smoking and health, health charities and provincial, territorial and federal Ministries of Health. Canadian Council for Tobacco Control www.nnsf.ca/about.html and The Lung Association www.lung.ca/home-accueil_e.php, are two of many agencies that have information on tobacco education, cessation programs and public health.

Thank You
Paul Williams, an RT instructor at Fanshawe College has recruited a record-setting 40 new CSRT members during the beginning of the school year. Thank you Paul for your outstanding efforts!

Merci
Paul Williams, enseignant de TR à Fanshawe College, a recruté 40 nouveaux membres de la SCTR, une quantité sans précédent, lors de la rentrée scolaire. Merci, Paul, pour tes efforts extraordinaires!
Algonquin College Open House
Portes ouvertes au Collège Algonquin


Les étudiants de 2e et de 3e année et le corps professoral du programme de thérapie respiratoire ont accueilli les professionnels cliniques de la région ainsi que le public. Les étudiants ont effectué des démonstrations révélant à quel point la simulation clinique constitue une partie intégrale de leur formation. Le centre de simulation et les laboratoires de thérapie respiratoire offrent des installations de simulation de fine pointe qui ont grandement rehaussé l’apprentissage des étudiants. Ces derniers peuvent exercer une gamme variée de compétences requises pour leur champ d’exercice dans un milieu non menaçant qui constitue une représentation réaliste de l’interaction avec le patient. Le simulateur de patient humain fournit aux étudiants une rétroaction réaliste à mesure qu’ils exécutent des compétences allant de la thérapie de base jusqu’aux compétences avancées liées aux soins de réanimation. Le corps professoral et les étudiants de tous les programmes ont exprimé des commentaires extrêmement positifs à savoir comment la simulation a transformé radicalement la formation au sein des programmes de soins de santé.

Algonquin College, in Ottawa, hosted an Open House on November 2nd, in the Algonquin College Simulation Centre for Health for the Respiratory Therapy Program and the programs associated with the Algonquin Connecting Expertise of the Internationally Trained (ACEIT) project. The ACEIT programs offer bridging training for individuals seeking employment in the Canadian health care system, building on the formal education and work experience they acquired in their home country. The ACEIT options include Polysomnography, Cardiac Diagnostics and integration into the full time Respiratory Therapy program. Prior Learning Assessment Recognition to access a national credential in Respiratory Therapy in association with the College of Respiratory Therapists of Ontario is also available. A program in Anesthesia Assisting is currently under development.

The second- and third-year students and faculty of the Respiratory Therapy program, welcomed area clinical practitioners and the public to the College. Students gave demonstrations of how clinical simulation is used as an integral part of their training process. The simulation centre and the Respiratory Therapy labs offer cutting edge simulation facilities that have greatly enhanced student learning. Students can perform a wide variety of clinical skills required for their scope of practice in a nonthreatening setting that at the same time provides a realistic representation of patient interaction. A Human Patient Simulator (HPS) provides realistic feedback to students as they perform skills ranging from basic therapy to advanced skills associated with critical care. Faculty and students of all the programs have given very positive commentary on how simulation has revolutionized training in health care programs.

CSRT National Exam
The next sitting of the CSRT National Certification Examination is January 7, 2008. Details for writing this exam are available at www.cbrc.ca.

Examen national de la SCTR
Did You Know? / Saviez-vous que?

**DID YOU KNOW?**
Washing laundry in hot water (60°C) kills 100% of dust mites associated with allergies. American Thoracic Society. www.thoracic.org

**DID YOU KNOW?**
In 2006, roughly one-fifth of prescribed drug expenses in Canada were paid directly out-of-pocket by households. www.cihi.ca

**DID YOU KNOW?**
Motor vehicle collisions are the second most common cause of injury resulting in deaths that occur in Canadian hospitals—unintentional falls are the first. Canadian Institute for Health Information. www.cihr-irsc.gc.ca

**DID YOU KNOW?**
Almost half of visits to hospital emergency departments last two hours or less. www.cihi.ca

**DID YOU KNOW?**
It has been estimated that there are 150,000 to 250,000 species of mold and fungi, the majority of which have not been identified. Although most fungi fulfill their critical ecologic role as saprophytes while having no contact with humans, a small number of fungal species have been implicated in human disease. ACP Medicine, American College of Physicians. www.acpmedicine.com

**DID YOU KNOW?**
Every eight seconds, someone in the world dies from a tobacco related illness; and every year tobacco kills 45,000 Canadians, and 2.5 million people world-wide. Health Canada. www.hcsc.gc.ca/index_e.html and thetruth.com

**SAVIEZ-VOUS QUE?**
Le fait de laver la lessive à l’eau chaude (60°C) tue 100 % des acariens de la poussière associés aux allergies. American Thoracic Society. www.thoracic.org

**SAVIEZ-VOUS QUE?**
En 2006, environ un cinquième des dépenses liées aux médicaments sur ordonnance au Canada ont été payées directement à partir du budget des ménages. www.cihi.ca

**SAVIEZ-VOUS QUE?**
Les collisions impliquant un véhicule à moteur constituent la deuxième cause de blessure la plus fréquente qui entraîne la mort dans les hôpitaux canadiens — les chutes accidentelles en sont la première. Institut canadien d’information sur la santé. www.cihr-irsc.gc.ca

**SAVIEZ-VOUS QUE?**
Près de la moitié des visites aux services d’urgences en milieu hospitalier s’échelonnent sur deux heures ou moins. www.cihi.ca

**SAVIEZ-VOUS QUE?**
Il est estimé qu’il existe entre 150 000 et 250 000 espèces de moisissure et de champignon, la majorité desquelles n’a pas été identifiée. Bien que la plupart des champignons exercent leur rôle écologique critique à titre de saprophytes sans aucun contact avec les êtres humains, un léger pourcentage d’espèces de champignon a été impliqué dans des maladies humaines. ACP Medicine, American College of Physicians. www.acpmedicine.com/

**SAVIEZ-VOUS QUE?**
À chaque huit secondes, quelqu’un au monde décède des suites d’une maladie liée au tabagisme; et à chaque année, le tabac tue 45 000 Canadiens et 2.5 millions de personnes à l’échelle mondiale. Santé Canada. www.hcsc.gc.ca/index_f.html et thetruth.com

**The top 10 reasons for getting the flu shot:**
10. You have a chronic medical condition
9. You have a weakened immune system
8. You’re a senior citizen
7. You’re 6–23 months of age
6. You’re a health care provider
5. You provide essential community services
4. You can’t afford the time off work
3. You’re traveling to another country
2. You live with someone who has a chronic medical condition

**Les 10 raisons pour lesquelles vous devriez recevoir le vaccin contre la grippe :**
10. Vous avez une condition médicale chronique
9. Vous avez un système immunitaire affaibli
8. Vous êtes du troisième âge
7. Vous êtes âgé entre 6 et 23 mois
6. Vous êtes prestataire de soins de santé
5. Vous assurez des services communautaires essentiels
4. Vous ne pouvez pas vous permettre de journées de congé
3. Vous prévoyez voyager dans un autre pays
2. Vous vivez avec une personne qui a une condition médicale chronique
I would like to start this issue’s message with a sincere thanks to all of the members who answered our call for help and got their proxies in on time for our Annual General Meeting. Although the Forum in Montreal was a smashing success, we were unable to move forward with a business meeting, as we didn’t have a quorum.

It seems that in spite of record attendance, the draw of touring around Old Montreal was too much for many and we were left a few people short. To remedy this situation we combined our Fall Board of Directors’ meeting with a Special General Meeting and we were able to get some much needed business done. With that, I am pleased to welcome Ray Hubble as the President-Elect and Jeff Dmytrowich as Director of National and Provincial Relations. You will hear a lot more from both of these individuals as they settle in their respective portfolios. I would also like to express my sincere thanks to Scott Lemessurier for his many years of service to the Board as the Director of National and Provincial Relations. Thank you, Scott. Your valued input and sense of humour will be missed.

Before I leave this topic however, I would like to draw everyone’s attention to the need for more interested people to join the Board. This coming year we have a large number of positions needing re-election. At our meeting in Montreal, I had an interesting discussion with another “old” RT. We both noted how much different the profession has become over the years. Not that the fundamental business of aerosol treatments or ventilator care has changed, but rather that the therapists of today are under the profession has become over the past many years. From fairly humble beginnings we have developed into a mature, science-based health care profession. We must not be content with our current position. Much, much more is needed.

The reason I pose these questions is that I am increasingly concerned that our voice is becoming lost in the cacophony of health care provider voices pleading for help. As a profession we have done remarkably well over the past many years. From fairly humble beginnings we have developed into a mature, science-based health care profession. We must not be content with our current position. Much, much more is needed.

This brings me back to those upcoming vacant Board positions. If you don’t get involved, who will? I know that you are busy; we are all busy in our own worlds. In addition to taking on a very complex educational management position, I am also pursuing my Master’s degree and trying to be a senior level administrator, today we find an increasing number of “respiratory therapy teams” reporting to a matrix or program form of management. As a result of this change, respiratory therapists have become distanced from the senior level of management and are often left to compete for all of their resources to lower-level managers.

Why be concerned you may ask; well for one thing — who advocates for the respiratory therapist? How does the senior level of management get to know what your skills are? Who speaks on your behalf when new directions are possible? Did the Hospital CEO know when Respiratory Therapy Week was or did you have just another day running from one patient to another?

The management structure of many hospitals has changed over the past decade. Where once we observed most departments reporting directly to a senior level administrator, today we find an increasing number of “respiratory therapy teams” reporting to a matrix or program form of management. As a result of this change, respiratory therapists have become distanced from the senior level of management and are often left to compete for all of their resources to lower-level managers.

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The reason I pose these questions is that I am increasingly concerned that our voice is becoming lost in the cacophony of health care provider voices pleading for help. As a profession we have done remarkably well over the past many years. From fairly humble beginnings we have developed into a mature, science-based health care profession. We must not be content with our current position. Much, much more is needed.

This brings me back to those upcoming vacant Board positions. If you don’t get involved, who will? I know that you are busy; we are all busy in our own worlds. In addition to taking on a very complex educational management position, I am also pursuing my Master’s degree and trying to be the President of this organization. Oh, and yes I have another life as a husband, father, grandfather, homeowner, handyman, gardener, and cook. Well you get the idea. I know that the same can be said by you, but don’t let that stop you from getting involved in some way. If you are not interested in a position on our Board, try becoming more involved in your own hospital. Become an advocate for your profession. Make contact with the CSRT and find out how we can help you with your initiative. In addition to some cool, CSRT branded wear, we can provide you with background and support material or put you in touch with experts that can make the difference in your proposals. The CSRT offers many opportunities to assist you. We take our Advocacy role seriously.

Another observation had to do with the lack of down time for many therapists. Today we see mainly 12-hour shifts filled from start to finish with everything you expect as a respiratory therapist and some things that you don’t. I have noticed that with the exception of a few specific times, there is no longer a slack time. Summers have ceased to become slow as the hospital empties so that vacations can be accommodated. So too have those shifts with only one or two ventilators and a couple of treatments. Most therapists are running from one very sick patient to another critically ill patient. Not only are people not getting a chance to catch their breath, they are having a harder time trying to get ready for the next round of activity. On this point fewer and fewer are willing to give up some of their “free” time to attend meetings or serve on professional committees.

Continued on page 14
Mot du président

J’aimerais débuter le mot du président de ce numéro en remerciant sincèrement tous les membres qui ont répondu à notre appel et qui ont acheminé leur formulaire de procuration à temps pour notre Assemblée générale annuelle. Comme vous le savez déjà, bien que le Forum à Montréal se soit avéré un succès retentissant, nous n’étions pas en mesure de tenir une séance de travail puisque nous n’avions pas atteint le quorum. En dépit d’une participation sans précédent, il paraît que l’attrait d’une visite du Vieux Montréal a plu à de nombreux délégués, de sorte qu’il nous manquait quelques personnes. Pour remédier à cette situation, nous avons combiné la réunion du Conseil d’administration de l’automne à une Assemblée générale extraordinaire et nous avons réussi à accomplir de nombreuses tâches importantes. Ainsi, il ne fait plaisir d’accueillir Ray Hubble à titre de président désigné et Jeff Dmytrovitch à titre de directeur des relations internationales et provinciales. Vous aurez des nouvelles de ces deux individus au fur et à mesure qu’ils s’installent dans leurs tâches respectives.

Avant de passer à un autre sujet, j’aimerais porter à l’attention de tous et chacun le besoin de recruter davantage de personnes intéressées au Conseil d’administration. De nombreux postes devront être comblés au cours de la prochaine année. Lors de notre réunion à Montréal, j’ai eu une discussion fort intéressante avec un TR d’expérience. Nous avons tous deux reconnu à quel point la profession a changé au fil des années. Ce ne sont pas les notions de base liées aux traitements à l’aérosol et aux soins respiratoires qui ont changé, mais plutôt, la pression accrue à laquelle les thérapeutes actuels sont confrontés. Je me suis demandé en quoi cela diffère du passé, et j’aimerais partager mes observations à ce sujet.

La structure de gestion de nombreux hôpitaux a subi des modifications au cours de la dernière décennie. Jadis, la plupart des services travaillaient sous l’autorité directe d’un administrateur de niveau supérieur mais de nos jours, de plus en plus « d’équipes de thérapie respiratoire » travaillaient sous l’autorité d’une gestion matricielle ou par programme. Ce changement a eu pour effet de distancer les thérapeutes respiratoires de la haute direction, les obligeant à compétitionner pour des ressources auprès de gestionnaires de niveau inférieur.

Pourquoi devrait-on s’en inquiéter? Pour une chose, qui défend les intérêts du thérapeute respiratoire? Comment la haute direction peut-elle apprécier vos compétences? Qui parle en votre nom lorsque de nouvelles directions deviennent possibles? Le chef de direction de votre hôpital savait-il que la Semaine de la thérapie respiratoire était en cours ou avez-vous vécu une autre journée bien ordinaire à courir d’un patient à l’autre?

Si je pose ces questions, c’est que je suis plus en plus préoccupé que notre voix est perdue dans la cacophonie de voix des prestataires de soins de santé qui crient : « À l’aide! » Comme profession, nous avons beaucoup progressé au cours des dernières années. De nos humbles débuts, nous sommes devenus une profession de soins de santé mûre et fondée sur la science. Par contre, il ne faut pas se contenter de notre position actuelle. Il reste encore beaucoup de travail à accomplir.

Cela me ramène aux postes qui devront être comblés au Conseil d’administration. Si vous ne vous impliquez pas, qui le fera? Je sais que vous êtes occupés, nous le sommes tous dans nos petits mondes. En plus d’avoir accepté un poste de gestion très complexe dans le domaine de l’éducation, je poursuis ma maîtrise et je tente de mon mieux d’assurer la présidence de cet organisme. En passant, j’ai une autre vie à titre d’époux, de père, grand-père, propriétaire d’une maison, jardinier et cuisinier.

Vous comprenez où je veux en venir. Vous pouvez sans doute en dire autant, mais ne laissez pas la multiplicité de vos rôles vous empêcher de vous impliquer d’une façon ou d’une autre. Si vous n’êtes pas intéressé à combler un poste au sein du Conseil d’administration, pourquoi ne pas vous impliquer davantage dans votre hôpital? Devenez défenseur de votre profession. Communiquez avec la SCRT pour savoir comment nous pourrions vous aider avec votre initiative. Outre les vêtements chics portant la marque de la SCRT, nous vous offrir des renseignements généraux et de la documentation d’appoint ou encore vous donner les coordonnées d’experts qui sauront rehausser vos propositions. La SCRT peut vous aider de plusieurs façons. Nous prenons notre rôle de défense des intérêts au sérieux.

Une autre de mes observations a trait à l’absence de temps mort pour de nombreux thérapeutes. De nos jours, les quarts de travail de 12 heures sont généralement remplis du début à la fin avec toutes sortes de cas dont on pourrait s’attendre à voir à titre de thérapeute respiratoire et même certains qui sont inattendus. J’ai remarqué qu’à l’exception de quelques moments spécifiques, il n’y a plus de morte saison. Il n’existe plus d’êtres au ralenti, comme jadis, alors que les hôpitaux se vidaient pour accomplanir les vacances, ni de quarts qui ne comportent qu’un ou deux ventilateurs et quelques traitements. La majorité des thérapeutes courent d’un patient très malade à un autre patient en phase critique. Non seulement les gens ont-il du mal à reprendre haleine, ils ont de plus en plus de difficulté à se préparer pour la prochaine vague d’activité. Par conséquent, de moins en moins de gens sont disposés à donner de leur temps « libre » pour participer à des réunions ou siéger à des comités professionnels. Je reviens encore à ma demande de vous impliquer.

Suite à page 14
In November 2006 the CSRT Board of Directors created a task force charged with the responsibility of reviewing the information and making a recommendation to the Board of Directors as to whether CSRT should proceed with looking into the possibility of offering international accreditation.

The first meeting of the International Task Force took place in April, 2007. Since then, the task force has researched progress and development by similar national and international organizations that are dealing with the same issues. Many accreditation groups are determining how they are going to proceed in the wake of these requests, and are looking at other organizations for direction. The American equivalent of CoARTE, (CoARC) does offer international accreditation, though only for satellite programs of approved American programs.

One program that has contacted CSRT for accreditation is the College of the North Atlantic — Qatar (CNA-Q) program. This is a satellite program of the College of the North Atlantic in Newfoundland. As part of the research, the task force sent a team to Qatar on an exploratory visit to do an initial review of the program. This will help determine whether CoARTE would be able to effectively accredit them using their current system.

The team of three, consisting of Raymond Hubble (CSRT president-elect), Mary Bayliss (Manager of Policy and Investigations, CRTO), and Pamela Hicks (Accreditation and Education Coordinator, CSRT) visited CNA-Q program in early November. They will report their findings to the International Task Force and following this report, the task force will make a recommendation to the CSRT Board of Directors. The final decision on whether CSRT will proceed with offering international accreditation and what parameters this will entail, will be the decision of the CSRT Board of Directors.

If you have any questions about the International Task Force, international accreditation or the accreditation of Canadian programs, please feel free to contact Pamela Hicks, Accreditation and Education Coordinator at phicks@csrt.com, or 800-267-3422 ext 26.
Le Michener Institute of Applied Health Sciences a accueilli l’équipe chargée de la responsabilité d’analyser les renseignements et de présenter une recommandation au Conseil d’administration à savoir si la SCTR doit étudier la possibilité d’offrir un agrément international.

La première réunion du Groupe de travail international a eu lieu en avril 2007. Depuis cette date, le groupe a effectué des recherches sur les développements et les progrès réalisés par des organismes nationaux et internationaux semblables qui sont confrontés aux mêmes questions. Plusieurs organismes d’agrément tentent de décider comment ils vont procéder dans la foulée de ces demandes et ils se tournent vers d’autres organismes pour une direction à suivre. L’homologue américain du CAFTR, le CoARC, offre un agrément international, quoique uniquement aux programmes satellites de programmes américains approuvés.

Un des programmes qui a communiqué avec la SCTR au sujet de l’agrément est le College of the North Atlantic — programme de Qatar (CNA-Q). Il s’agit d’un programme satellite du College of the North Atlantic à Terre-Neuve. Dans le cadre de sa recherche, le groupe de travail a dépêché une équipe à Qatar en visite d’exploration pour effectuer une révision initiale du programme. L’information recueillie permettra de déterminer si le CAFTR est en mesure de l’agréer avec son système actuel.

L’équipe de trois personnes, Raymond Hubble (président désigné de la SCTR), Mary Bayliss (directrice des politiques et investigations, OTRO) et Pamela Hicks (coordonnatrice des services d’agrément et d’éducation, SCTR) a visité le programme du CNA-Q au début novembre. Elle fera rapport de ses conclusions au Groupe de travail international et, suite à la réception du rapport de l’équipe, le groupe de travail présentera ses recommandations au Conseil d’administration de la SCTR. La décision finale en matière d’agrément international et des paramètres qui seraient requis revient au Conseil d’administration de la SCTR.

Pour toute question au sujet du Groupe de travail international, de l’agrément international ou de l’agrément de programmes canadiens, n’hésitez pas à communiquer avec Pamela Hicks, coordonnatrice des services d’agrément et d’éducation à l’adresse phicks@csrt.com ou au 800-267-3422, poste 26.
President’s Message continued from page 10

Once again I come back to asking you to get involved.

I know that many of you have very full and active lives. Work, home and school often leave us with little time left to just sit and relax or read a book. Multitasking is the “soup de jour” for most of us. Yet within this framework each of you has to ask yourself what it is that makes you come back every day as a respiratory therapist. Surely all that you have seen in your career would have caused others to curl up into a tight fetal position long ago. You are a very special breed of therapists who give everything you have and more to your patients day-in and day-out. The CSRT needs you in order to ensure that there is something for the next generation of therapists. Please consider what your life would be like if we were not able to advocate for you or provide leadership within the profession. Consider adding just a few more hours of your time and become an active member of your professional society. You might be surprised at how rewarding it is.

Make your mantra the same as the CSRT.

“Leadership through Advocacy, Service and Unity for Respiratory Therapists in Canada”

Rob Leathley, B.Ed., RRT
CSRT President

CSRT VAP Workshop

On October 16, 2007, CSRT hosted another professional development workshop. The topic was Ventilator Association Pneumonia (VAP), presented by Richard Milo from Kelowna, BC. This workshop was a combination of web and teleconferencing services, allowing participants from across the country to take part. Twenty-one sites registered and participated in for this event.

If you would like additional information on CSRT’s professional development workshops, or have a topic that you would like to see presented, please contact Pam Hicks, Accreditation and Education Coordinator at phicks@csrt.com, or 800-267-3422 ext 26.

This workshop was generously sponsored by Covidien

Atelier de pneumonie sous ventilation assistée de la SCTR

Le 16 octobre 2007, la SCTR s’est fait l’hôte d’un autre atelier de perfectionnement professionnel. Le sujet, Ventilator Associated Pneumonia, était présenté par Richard Milo de Kelowna, en Colombie-Britannique. L’atelier était offert grâce à une combinaison de services Web et de téléconférence, ce qui permettait aux intéressés d’un bout à l’autre du pays d’y participer. Vingt-et-un sites se sont inscrits et ont participé à cette activité.

Pour un complément d’information sur les ateliers de perfectionnement professionnel de la SCTR ou proposer un sujet d’atelier, veuillez communiquer avec Pam Hicks à l’adresse phicks@csrt.com ou au 800-267-3422, poste 26.

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On October 20, 2007, the CSRT held a properly constituted Annual General Meeting (AGM) of the CSRT membership. The AGM is where a corporation completes a number of items of business as required by Industry Canada.

Some of these items of business include the presentation of financial statements, approval of the corporations auditor, election of officers, and ratification of changes to the organization’s bylaws and other corporate documents.

At this year’s AGM all items were approved, including a bylaw change to allow the addition of a new Board position for a student member. This new Board position will give the student members a voice on the CSRT Board of Directors, and will also provide insight to the Board on how to better engage the student population. We look forward to getting this position filled so that we can work with and learn from this new member.

Also at this AGM, the members ratified the new additions to the Board of Directors. We welcome Ray Hubble as President-Elect, and Jeff Dmytrovitch in National-Provincial Relations portfolio. Ray has a long history with the CSRT, as a Board member, and through participation in various committees. We welcome his wealth of knowledge and experience. Jeff is a young and up and coming star in our profession. He brings a sound knowledge of the practice of respiratory therapy as well as a deep understanding of technology and a sense of innovation. Jeff is also the author of the only respiratory therapy blog in Canada. For Jeff’s views on the practice check it out at www.resptherapy.com.

As of this AGM, the Board also says goodbye to Scott Lemessurier, of Grand Falls-Windsor, NL. Scott came onto the Board in 2004 as one of the original members of the revised Board of Directors structure. Scott provided the Board and Head Office with invaluable input and direction for the past three years, and he will be greatly missed.

The reason the AGM was held in the fall this year was because we did not have adequate attendance to hold an official AGM during the annual conference this year. Difficulty obtaining quorum at the AGM has been an annual issue and because of this Board is reviewing its quorum requirement, and will be presenting its findings to the membership at the AGM to be held in the spring of 2008, in Saskatoon, SK.

Doug Maynard BSc, RRT, MBA
Executive Director

Rapport de l’AGA de la SCTR

Le 20 octobre 2007, la SCTR a tenu une Assemblée générale annuelle proprement constituée de ses membres. Conformément aux exigences d’Industrie Canada, c’est lors de l’AGA qu’une société constituée en personne morale traite de nombreux sujets.

Entre autres, ces sujets comprennent la présentation des états financiers, l’approbation des vérificateurs de la société, l’élection des administrateurs et la ratification des changements aux statuts et aux autres documents officiels de l’organisme.

À l’AGA de cette année, tous les sujets proposés ont été approuvés, y compris une modification aux statuts permettant d’ajouter un nouveau poste au Conseil d’administration, soit un membre étudiant. Ce nouveau poste assurera aux membres étudiants une voix au Conseil d’administration de la SCTR et donnera au CA un aperçu des moyens d’impliquer davantage la population étudiante. Nous avons hâte de combler ce poste afin d’apprendre du nouveau membre et de travailler avec lui ou elle.


Enfin, c’est lors de cette AGA que le Conseil d’administration a dit au revoir à Scott Lemessurier de Grand Falls-Windsor, T.-N. Scott est l’un des membres fondateurs du Conseil d’administration restructuré, s’étant joint au CA en 2004. Au cours des trois dernières années, il a su contribuer une direction et de précieuses rétroactions au Conseil d’administration et au bureau chef et il nous manquera grandement.

Cette année, l’AGA a eu lieu à l’automne en raison de l’insuffisance des participants pour tenir une AGA officielle dans le cadre de la conférence. La difficulté d’assurer le quorum à l’AGA est un problème annuel et par conséquent, le Conseil d’administration établit ses exigences en matière de quorum. Il présentera les résultats de cette analyse aux membres lors de l’AGA prévue à Saskatoon, SK, au printemps 2008.

Doug Maynard TRA, MBA

Douglas Maynard BSc, RRT, MBA
Executive Director
The Canadian Respiratory Therapy Foundation was a registered charity, designed to accept donations and promote research and education in respiratory therapy.

La Fondation canadienne de la thérapie respiratoire (FCTR) était un organisme de bienfaisance enregistré, conçu pour accepter des dons et promouvoir la recherche et l’éducation dans le domaine de la thérapie respiratoire.

Due to lack of donations, and funding, for an extended period of time, the CRTF is no longer able to perform its duties as a charity. The current CRTF Board of Directors recently met, and agreed to dissolve the corporation.

The CRTF will be dissolved, and all assets will be distributed as per Industry Canada requirements. The remaining assets will be given to the CSRT, for the purpose of continuing the mandate of supporting research/education and encouraging recognition of excellence in respiratory therapy.

The CSRT will also continue to work directly with supporters, such as Summit Technologies and Medigas/Praxair, to promote awards that recognize the achievements of our respiratory therapy community.

If you would like more information about the CRTF or details about the dissolution, please contact Doug Maynard at 800-267-3422, ext 22 or dmaynard@csrt.com.

En raison du manque de dons, et de financement, qui perdure depuis longtemps déjà, la FCTR n’est plus en mesure de s’acquitter de ses tâches à titre d’organisme de bienfaisance. Le Conseil d’administration actuel de la FCTR s’est rencontré récemment et a conclu à la dissolution de l’entité juridique.

La FCTR sera dissoute et tous les actifs seront distribués en fonction des exigences d’Industrie Canada. Les éléments d’actif non réalisés seront remis à la SCTR dans le but de poursuivre le mandat de soutenir l’éducation/la recherche et de favoriser la reconnaissance de l’excellence en thérapie respiratoire.

La SCTR continuera également à travailler directement avec les supporteurs, tel Summit Technologies et Medigas/Praxair, afin de promouvoir des prix qui soulignent les succès de notre communauté de thérapie respiratoire.

Pour un complément d’information au sujet de la FCTR ou des détails relatifs à la dissolution, prière de joindre Doug Maynard au 800-267-3422, poste 22 ou à dmaynard@csrt.com.

Respiratory Care Supplement Published by Canadian Pharmacists Journal

The Canadian Pharmacists Journal has recently released its latest special supplement supporting pharmacists in the provision of respiratory care. As one of the most accessible healthcare providers, pharmacists are in an excellent position to identify patients who may have undiagnosed or uncontrolled asthma, or who may be in the early stages of COPD. This supplement, Respiratory Care, includes pharmacist-specific summaries of recent practice guidelines for asthma and COPD as well as practice tips and tools. Visit their website for details www.pharmacists.ca.

RT Week Contest

Our annual RT Week booth contest has attracted a huge response from across the country. CSRT staff is hard at work trying to pick winners. Prizes for the most original and awareness-generating displays will be announced in the Spring CJRT.
Respiratory Therapy Week 2007: A Great Success
Doug Maynard BSc, RRT, MBA; Executive Director

Respiratory therapists from across Canada went into the streets to promote their profession and show their pride in being RTs during RT Week this year.

As part of our ongoing efforts to promote respiratory therapy, the CSRT and local members secured locations in a number of shopping malls, where RRTs could engage the public.

Promoting respiratory therapy to the general public, it is always an eye opening experience. Many of the visitors to the displays have never heard of the profession, and others come with some interesting, pre-conceived notions of what it is that we do. These displays provide an excellent opportunity to properly educate the public about our diverse role within the healthcare system.

There are also many individuals who are fully aware of the value of RRTs, often as a result of receiving treatment from an RRT, either as a patient themselves, or as a family member of someone who has spent time in an ICU or other healthcare setting. In my personal experience in working in these displays, I have never heard anything but positive comments. Whether it’s an old COPD’er that knows to ask for the RT to perform his ABG, or whether it is the thankful parent of a, now healthy, premature infant, these individuals often use this opportunity to express their gratitude. It is these interactions that make 10 hours spent sitting in the hallway of a shopping mall worthwhile.

Some of the more common questions from visitors to the displays are from teenagers and young adults that are interested in respiratory therapy as a career choice. These displays always provide a great opportunity to demonstrate your pride in being an RT and to give information on what it’s really like to be an RT.

The CSRT assisted members in securing nine mall locations across Canada, and provided promotional material, banners, and other advice on making booths more attractive.

All of the mall locations provided space, and other resources, either free of charge, or at a significantly reduced rate.

The CSRT would like to thank RRTs for taking the time to help out our profession by leading these promotional initiatives. Many of these individuals had other local RRTs helping them at their displays, and our thanks go out to them as well.

We would also like to thank the following shopping malls for providing space for us to set up these displays. All of the locations were very helpful, and we hope to come back again next year.

The CSRT would also like to thank the many individuals that set up promotional displays at their workplace, schools or other locations. Many of these individuals took the initiative to establish their own locations, and the CSRT was happy to provide them with promotional materials to help their displays.

This list represents a small sample of the RRTs across Canada that made a significant contribution of their time and resources, in an attempt to improve public awareness of respiratory therapy during this year’s RT Week.

All of the members that received promotional information from the CSRT will also have found RT Week T-shirts in their packages. Summit Technologies, celebrating their 25th Anniversary, graciously provided these T-shirts. The CSRT would like to thank Summit Technologies for providing the shirts, and for once again demonstrating their never-ending creativity in designing the artwork for the shirts.

Thank you again to everyone that contributed to making this year’s RT Week a great success.

RT Week Mall Displays

<table>
<thead>
<tr>
<th>Lead RRT</th>
<th>City</th>
<th>Location</th>
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<tbody>
<tr>
<td>Lisa Butcher</td>
<td>Kelowna, BC</td>
<td>Orchard Park Shopping Mall</td>
</tr>
<tr>
<td>Flora Ducharme</td>
<td>Lethbridge, AB</td>
<td>Park Place Mall</td>
</tr>
<tr>
<td>Carrie-Lynn Meyer</td>
<td>Hamilton, ON</td>
<td>Centre Mall</td>
</tr>
<tr>
<td>Ian Summers/Jackie Bernard</td>
<td>Ottawa, ON</td>
<td>St. Laurent Shopping Centre</td>
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<tr>
<td>Patricia Moriarty</td>
<td>Halifax, NS</td>
<td>Mic Mac Mall</td>
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<tr>
<td>Janice Langis</td>
<td>Moncton, NB</td>
<td>Highfield Square</td>
</tr>
<tr>
<td>Teresa Wasend</td>
<td>Saskatoon, SK</td>
<td>The Mall at Lawson Heights</td>
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<tr>
<td>Tammie Fournier</td>
<td>St. John, NB</td>
<td>McAllister Place Mall</td>
</tr>
<tr>
<td>Carol Mullin</td>
<td>Penticton, BC</td>
<td>Cherry Lane Mall</td>
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RT Week Individual Displays

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<thead>
<tr>
<th>Lead RRT</th>
<th>City</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jumana Hossein</td>
<td>Toronto, ON</td>
<td>Michener Institute</td>
</tr>
<tr>
<td>Amanda Henein</td>
<td>London, ON</td>
<td>Fanshawe College</td>
</tr>
<tr>
<td>Cheryl Adams</td>
<td>Edmonton, AB</td>
<td>Capital Health Homecare</td>
</tr>
<tr>
<td>John Bolger</td>
<td>Kimberley, BC</td>
<td>Kimberly Health Center</td>
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<tr>
<td>Dan McPhee</td>
<td>Goderich, ON</td>
<td>Alexandria Marine and General Hospital</td>
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<tr>
<td>Lisa Spooner</td>
<td>Ottawa, ON</td>
<td>Children’s Hospital of Eastern Ontario</td>
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<tr>
<td>Helen Parker</td>
<td>Toronto, ON</td>
<td>Bloorview Kids Rehab</td>
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<tr>
<td>Mary Ann Enskon</td>
<td>Sudbury, ON</td>
<td>Sudbury Regional Hospital</td>
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<tr>
<td>Daphne Marrs</td>
<td>Ottawa, ON</td>
<td>Saint-Vincent Hospital</td>
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<tr>
<td>Deanna West</td>
<td>Lindsay, ON</td>
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<tr>
<td>Lisa Lern</td>
<td>Edmonton, AB</td>
<td>Cross Cancer Institute</td>
</tr>
<tr>
<td>Donna Young</td>
<td>Windsor, NS</td>
<td>Hants Community Hospital</td>
</tr>
</tbody>
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Deanna West
La Semaine de la thérapie respiratoire 2007, un succès retentissant
Doug Maynard TRA, MBA; Directeur général

Cette année, les thérapeutes respiratoires d’un bout à l’autre du Canada sont descendus dans les rues pour promouvoir leur profession et afficher leur fierté d’être des TR pendant la Semaine de la TR.

Dans le cadre de nos efforts continus en vue de promouvoir la thérapie respiratoire, la SCTR et les membres locaux ont obtenu l’accès à des endroits dans plusieurs centres d’achats, où les TRA pouvaient échanger avec le public.

Quiconque a déjà saisi l’occasion de promouvoir la thérapie respiratoire auprès du grand public confirmera qu’il s’agit toujours d’une expérience révélatrice. Bon nombre des visiteurs aux kiosques n’ont jamais entendu parler de la profession, alors que d’autres ont d’intéressantes idées préconçues sur ce que nous faisons. Ces kiosques fournissent une occasion idéale pour renseigner correctement les gens à l’égard de notre rôle diversifié au sein du système de soins de santé.

Bien sûr, il y a également beaucoup de gens qui connaissent très bien la valeur des TRA, soit parce qu’ils ont reçu, en tant que patients, des soins d’un TRA, ou à titre de membre de la famille d’une personne qui a effectué un séjour aux soins intensifs ou dans un autre milieu de soins de santé. Par expérience personnelle avec ces kiosques, je n’ai entendu que des commentaires positifs. Qu’il s’agisse d’une personne âgée atteinte de MPOC qui sait qu’elle doit demander un TR pour effectuer l’analyse des GSA, ou le parent reconnaissant d’un bébé prématuré, maintenant en santé, ces gens saisissent souvent cette occasion pour exprimer leur gratitude. Ces interactions donnent tout son sens aux 10 heures passées assis dans le couloir d’un centre d’achats.

Souvent, les adolescents et les jeunes adultes qui visitent les kiosques posent des questions sur la thérapie respiratoire à titre de choix de carrière. Les kiosques constituent toujours une excellente façon de démontrer votre fierté d’être TR et de fournir des renseignements à savoir ce que ça signifie vraiment d’être TR.

La SCTR a aidé les membres à obtenir l’accès à neuf endroits dans des centres d’achats à travers le pays. Elle leur a également fourni du matériel promotionnel, des bannières et des conseils sur les façons de rehausser l’aspect esthétique de leur kiosque.

Tous les endroits dans les centres d’achats ont offert l’espace, et d’autres ressources, gratuitement ou à un tarif très avantageux.

La SCTR souhaite remercier les TRA suivants d’avoir pris le temps d’aider la profession en dirigeant des initiatives promotionnelles. Plusieurs de ces personnes étaient assistées par d’autres TRA locaux, et nous les remercions, eux aussi.

Nous souhaitons également remercier les centres d’achats suivants d’avoir offert de l’espace nous permettant d’installer nos kiosques. Chacun des endroits s’est avéré très utile et nous espérons revenir l’an prochain.

La SCTR souhaite également remercier les nombreuses personnes qui ont installé des expositions promotionnelles dans leur milieu de travail, école, ou autre endroit. Plusieurs d’entre elles ont pris l’initiative de se trouver un endroit et la SCTR s’est fait un plaisir de leur fournir du matériel promotionnel pour étoffer leur kiosque.

Cette liste représente un petit échantillon des TRA de partout au Canada qui ont fait une importante contribution en temps et en ressources, dans le but de rehausser la sensibilisation du public à l’égard de la thérapie respiratoire pendant l’édition 2007 de la Semaine de la TR.

Tous les membres qui ont reçu du matériel promotionnel de la SCTR ont également trouvé des t-shirts de la Semaine de la TR dans leur trousse. Summit Technologies, qui célèbre son 25e anniversaire, a gracieusement offert ces t-shirts. La SCTR désire remercier Summit Technologies d’avoir fourni les t-shirts et démontré, encore une fois, sa créativité sans limite dans la conception de l’illustration destinée aux t-shirts.

Encore une fois, merci à tous ceux qui ont contribué au franc succès de la Semaine de la TR de cette année.

TRA en chef | Ville | Lieu
--- | --- | ---
Lisa Butcher | Kelowna, BC | Orchard Park Shopping Mall
Flora Ducharme | Lethbridge, AB | Park Place Mall
Carrie-Lynn Meyer | Hamilton, ON | Centre Mall
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Mary Ann Eriksen | Sudbury, ON | Sudbury Regional Hospital
Daphne Mars | Ottawa, ON | Saint-Vincent Hospital
Deanna West | Lindsay, ON | Cross Cancer Institute
Lisa Lem | Edmonton, AB | Hants Community Hospital
Donna Young | Windsor, NS | Hants Community Hospital
CSRT Membership Services
Tracy Taylor, CSRT Director of Operations and Membership Services

I would like to take this opportunity to introduce myself. I am CSRT’s Director of Operations and Membership Services. Before arriving at CSRT in March, I was previously the Director of Operations at Sport Physiotherapy Canada for seven years and most recently, four years as Membership Services Manager at the Canadian Association of Occupational Therapists.

CSRT is truly a wonderful organization to work for and we have great staff members here at head office that all work together to ensure that you, as our members receive the best services possible.

Thank you all for your ongoing support of CSRT. It is members like you who make the health care world take notice of the profession of respiratory therapy. We have been working very hard at Head Office to make sure that we have the best possible benefits for our members.

One of those benefits is professional liability insurance. We have been working closely with our insurance broker Marsh Canada to ensure that we have the best professional liability insurance program possible in place for the best premiums possible. In a nutshell, the more members that we have enrolled in the program, the better we are able to negotiate the best rates and coverage for you. As it stands now, we have over 1,000 members enrolled in the program, which definitely gives us a strong voice with the insurance provider.

Since I have been working on this venture, we have been able to negotiate the additional coverage of “12 months extended discovery”, to your already existing 2007–08 insurance program. This means that your current “Errors and Omissions Liability policy automatically includes an extended discovery period of 12 months should you no longer work or give advice as a respiratory therapist (i.e. retire, become disabled, go on maternity/parental leave, or voluntarily give up your license to practice as a respiratory therapist).” We are currently investigating the possibility of offering different options for your insurance, with more comprehensive coverage, so keep an eye out for future issues of the CJRT and your renewal package in the spring.

For more information regarding the insurance program and other membership benefits, please visit our website at www.csrt.com and go to the Member Benefits section of the website and download our new brochure and Frequently Asked Questions (FAQs).

There will also be more on the insurance program and other member benefits mentioned in our CSRT E-News. Please ensure that we have your most up to date e-mail address, so that you do not miss any of these informative e-mail blasts. If you have not been receiving our E-News, please update your profile on our website or contact csrt@csrt.com.

Thanks again for your support of CSRT.

Thank You Summit
Volunteers at RT Week booths were especially well dressed in t-shirts generously sponsored by Summit Technologies. Each volunteer received a “Breathing Life into Healthcare” t-shirt to help promote respiratory therapy. Thanks to Jim Cosman and Murray Beaton of Summit Technologies for their impressive efforts!

Merci Summit
Les bénévoles aux kiosques de la Semaine de la TR étaient particulièrement bien habillés, revêtant des t-shirts généreusement commandités par Summit Technologies. Dans le but de promouvoir la thérapie respiratoire, chaque bénévole a reçu un t-shirt où on pouvait lire « Breathing Life into Healthcare ». Merci à Jim Cosman et à Murray Beaton de Summit Technologies pour leurs efforts impressionnants!
Services aux membres de la SCTR

Tracy Taylor, Directrice des opérations et des services aux membres de la SCTR

J’aimerais profiter de cette occasion pour me présenter. Je suis la directrice des opérations et des services aux membres de la SCTR. Avant de me joindre à la SCTR en mars dernier, j’ai occupé le poste de directrice des opérations à Sport Physiotherapy Canada pendant sept ans et, plus récemment, celui de directrice des services aux membres à l’Association canadienne des ergothérapeutes pendant quatre ans.

La SCTR est un organisme où il fait bon travailler : les membres du personnel au bureau chef travaillent tous ensemble afin de veiller à ce que vous, les membres, receviez les meilleurs services possibles.

Merci de votre soutien continu à l’égard de la SCTR. Ce sont des membres comme vous qui font en sorte que le monde des soins de santé prenne connaissance de la profession de la thérapie respiratoire. Au bureau chef, nous travaillons d’arrache-pied de façon à pouvoir offrir à nos membres les meilleurs avantages qui soient.

Parmi ces avantages figure l’assurance responsabilité professionnelle. Nous travaillons de près avec notre courtier d’assurance, Marsh Canada, afin de nous assurer d’avoir en place le meilleur programme d’assurance possible aux plus basses primes possibles. En gros, plus de membres sont inscrits au programme, mieux nous sommes en mesure de négocier les meilleurs taux et la meilleure couverture pour vous. À présent, au-delà de 1 000 membres sont inscrits au programme, ce qui nous confère sans contredit une voix solide auprès du fournisseur d’assurance.

Depuis que je travaille à ce dossier, nous avons réussi à négocier une couverture additionnelle, soit une « période de prolongation de garantie de 12 mois advenant que vous cessiez de travailler ou de prodiguer des conseils à titre de thérapeute respiratoire (p. ex. si vous prenez votre retraite, êtes frappé d’incapacité, prenez un congé parental / de maternité ou renoncez volontairement à votre permis d’exercer à titre de thérapeute respiratoire). » [traduction libre] Nous étudions présentement la possibilité d’offrir diverses options liées à votre programme d’assurance, y compris une couverture plus complète. Des renseignements additionnels vous seront communiqués dans les futurs numéros de la RCTR et dans votre trousse de renouvellement d’adhésion au printemps.


Par ailleurs, des informations supplémentaires sur ces deux mêmes sujets seront publiées dans le CyberBulletin de la SCTR. Assurez-vous que nous avons votre adresse de courriel afin de ne pas manquer ces renseignements électroniques informatifs. Si vous ne recevez pas notre CyberBulletin, veuillez mettre votre profil à jour dans notre site Web ou écrivez à csrt@csrt.com.

Merci encore une fois de votre soutien vis-à-vis de la SCTR.

RT Mentors Needed

Do you want to:
■ Stay connected to your alma mater?
■ Keep current with new trends in education?
■ Become more self-aware of your leadership style?
■ Build your professional network?
■ Participate in the hottest career advancement trend?

Mentoring For Success matches Fanshawe Alumni with motivated students and recent grads to help them make smooth school-to-work transitions and to provide opportunities to explore their chosen career path.

Currently, we have a need for Mentors in the Respiratory Therapy field. Preference will be given to Fanshawe grads, but all applications are welcome.

For more information, visit our website at www.mentoringforsuccess.ca or contact the Mentoring For Success Coordinator, Jen Denys, at jdenys@fanshawec.ca.
CSRT Conference 2008

The Canadian Society of Respiratory Therapists is pleased to announce the annual National Respiratory Therapy Conference and Trade Show will be held at Saskatoon Arts & Convention Centre (TCU Place), Saskatoon, SK, May 22 and 25, 2008. This is the largest respiratory event of this kind in Canada.

HIGHLIGHTS INCLUDE:

KEYNOTE SPEAKERS

Doctors Without Borders
Dr. Richard Heinzl, Toronto, ON

High Frequency Ventilation in Adults Management of ALI/ARDS
Dr. Thomas E. Stewart, Professor of Medicine and Anaesthesia; University of Toronto Director, Critical Care Medicine, Mount Sinai Hospital and University Health Network, Toronto, ON

Sleep Disordered Breathing in Adults
Dr. John Fleetham, Respiratory Medicine, Diamond Health Care Centre, Vancouver, BC

The Gender Lens: Issues in Respiratory Disease
Libby Groff, R.R.T., B.H.A; Manager Ambulatory Cardio-Pulmonary, WCH

The Health Sciences Centre, Toronto, ON

Toronto Director, Critical Care Medicine, Medicine and Anaesthesia; University of Dr. Thomas E. Stewart, Professor of Medicine and Anaesthesia, Mount Sinai Hospital, Toronto, ON

Highlight Events:

Mingle with delegates, speakers and Thursday, May 22 – 6 PM

Thursday, May 22 – 9 AM

Anesthesia, Mount Sinai Hospital, Toronto, ON

Hospital, Saskatoon, SK

Dr. Leslie Dort, Calgary, AB

Dr. Sheldon Wiebe, Department of Medical Imaging, Royal University Hospital, Saskatoon, SK

Dr. Christer Sinderby, MSc, PhD

Discovering the Earliest Origins of Disease; Pediatric Solutions to Health Care Crisis
Dr. Alan Rosenberg, Department of Pediatrics, Royal University Hospital, Saskatoon, SK

Neonatal & Pediatric Chest X-ray Interpretation
Dr. Sheldon Wiebe, Department of Medical Imaging, Royal University Hospital, Saskatoon, SK

Methamphetamine/Overdose
Dr. Jon Witt, MD, CCFP(EM), Emergency Department, Royal University Hospital, Saskatoon, SK

SPECIAL ACTIVITIES

Annual Leadership Congress
Thursday, May 22 – 9 AM

Annual Educator’s Congress
Thursday, May 22 – 9 AM

CSRT Wine and Cheese Reception
Thursday, May 22 – 6 PM

Wine with delegates, speakers and exhibitors at this complimentary event that is the opening of the Exhibit Hall.

Airway Olympics — Back by popular demand!
Friday, May 23 – 1:30 PM

Rick Paradis RRT, Charge Therapist — O.R., Respiratory Therapy Department/Anesthesia, Mount Sinai Hospital, Toronto, will be in charge of this event. Intubation techniques will be timed, recorded and displayed for everyone to see. These techniques will show you that there are many ways to establish an airway and will teach you some of your own physical limitations! Sign up your teams four!

Saskatoon Social — Sponsored in part by Roxon
Friday, May 23 – 6:30 PM

We will meet at the historic Odeon Theatre — to watch the Wauskwewin International Dance Troupe express their First Nations culture through song and dance. This will be followed by the vibrant Ukrainian Dance ensemble. This complimentary evening will also feature an array of ethnic finger foods.

RTs on Trial — Is your practice defendable under cross examination?
Saturday, May 24 – 9 AM

During the first part of the session the speaker will discuss what litigation lawyers look for when determining whether or not to bring forward a lawsuit. They will also talk about the type of charting that will help you defend yourself in court. The second part of the session will be a mock trial. Volunteers will be asked to chart based on a scenario that is presented to them. The volunteers will then be cross-examined by the lawyer to see if their charting really will help them on the witness stand.

CSRT President’s Banquet and Awards
Saturday, May 24 – 6:30 PM

The CSRT will present its annual awards. The versatile band — “Hot Tamales” will perform after dinner.

A block of rooms has been reserved at the Hilton Garden Inn, and discounted air fares are available with WestJet. New information will be posted as it becomes available.
New COPD Guidelines

The Canadian Thoracic Society (CTS) has released new guidelines for the treatment of chronic obstructive pulmonary disease (COPD). The Canadian Thoracic Society recommendations for management of chronic obstructive pulmonary disease — 20071 is based on the latest evidence and provides physicians with the most up-to-date information for treating this debilitating disease.

COPD is a progressive lung disease which includes chronic bronchitis and emphysema. More than 714,000 Canadians have been diagnosed with COPD and there are estimated to be thousands more who have not yet been diagnosed2. In 2007 alone, approximately 9,000 Canadians will die from COPD3 and the incidence of the disease is steadily increasing. It is predicted that by 2020 COPD will be the third leading cause of death worldwide4.

“Recently, the number and size of randomized clinical trials in the area of COPD have increased dramatically,” says Dr. Paul Hernandez, a member of the CTS COPD Guidelines Development Committee and Associate professor of Medicine at Dalhousie University. “Major studies like TORCH and OPTIMAL have provided us with a wealth of new evidence on which to base these treatment recommendations and reinforce that COPD is a treatable, preventable and under-diagnosed disease.”

Changes to the Guidelines

Two of the most significant areas addressed by the 2007 guidelines are the prevention and management of exacerbations and new algorithms to ensure patients are receiving adequate therapy appropriate to their disease severity.

Exacerbations or worsening of symptoms can be triggered by simple occurrences such as a common cold, change in weather, or allergies. They can often result in visits to the local Emergency Department, hospitalization and, in severe cases, can lead to death.

“It’s vital that physicians recognize the importance of exacerbations in the life of a patient with COPD,” says Hernandez. “COPD is not just a nuisance disease that people live with, but a serious disease that people die from. We should consider exacerbations in COPD patients as important as myocardial infarction in people with ischemic heart disease. We need to not only prevent the first exacerbation, but work more proactively to prevent all subsequent flare ups of the disease.”

New treatment algorithms outline optimal pharmacological and non-pharmacological management for COPD according to disease severity. With appropriate treatment, patients with COPD should expect to experience less shortness of breath, better exercise tolerance, fewer hospitalizations and improved quality of life.

Other key areas addressed in the 2007 guidelines include:

New information regarding the epidemiology of COPD based on the Burden of COPD in Canada survey.

Rates of COPD prevalence have been underestimated and are continuing to increase, particularly among women. COPD is now the fourth leading cause of death in Canada.

The link between COPD and co-morbidities.

There is now evidence to associate COPD with co-morbid diseases, including CVD, cancer, osteoporosis, glaucoma, cataracts, depression and malnutrition.

Classification of disease severity.

The revised guidelines address the measurement of airflow through spirometry to be more aligned with international guidelines, while still recognizing the importance of symptoms as measures of functional disability.

Regional disparity in access to pulmonary rehabilitation programs, patient education and coverage for medications.

Implications of 2007 Guidelines for Clinical Practice

The 2007 guidelines emphasize the importance of spirometry as not just a diagnostic tool for COPD, but to determine which patients will benefit most from specific pharmacological interventions.

“The important take-away message for physicians from the revised guidelines is that this is a treatable disease, and with the right treatment options available, patients can do better,” says Dr. Denis O’Donnell, Chair of the CTS COPD Guidelines Development Committee and Professor of Medicine and Physiology, Queen’s University. “Through early diagnosis and correct assessment of disease severity through spirometry testing, along with early and aggressive treatment with both lifestyle changes and medications, COPD can be managed and patients can maintain an improved quality of life.”

Continued on next page
COPD continued from previous page

The revised COPD guidelines can be found at www.copdguidelines.ca. Additional respiratory guidelines produced by the CTS can be found at www.lung.ca/cts-sct under Guidelines and Standards.

The Canadian Thoracic Society (CTS), founded in 1958, is the medical section of The Lung Association. The CTS promotes lung health by supporting the respiratory community through leadership, collaboration, research, learning and advocacy and by promoting the best respiratory practices in Canada. It also advises The Lung Association on scientific matters.

These guidelines were developed under the auspices of the Scientific Review Panel of the Canadian Thoracic Society. This process was facilitated by funding from ALTANA Pharma Inc, AstraZeneca Canada Inc, Bayer Canada Inc, Boehringer Ingelheim (Canada) Inc, Bristol-Myers Squibb, GlaxoSmithKline Inc and Pfizer. None of the pharmaceutical sponsors played a role in the collection, review, analysis or interpretation of the scientific data or in any decisions regarding recommendations.

References

La Société canadienne de thoracologie (SCT) a publié de nouvelles lignes directrices sur la prise en charge de la maladie pulmonaire obstructive chronique (MPOC). Fondées sur les dernières données probantes, les « Recommandations de la Société canadienne de thoracologie au sujet de la prise en charge de la maladie pulmonaire obstructive chronique — Mise à jour de 2007 » fournissent aux médecins des renseignements très récents sur le traitement de cette maladie débilitante.

Modifications aux lignes directrices
Les deux principaux domaines visés par les lignes directrices de 2007 sont la prévention et la prise en charge des exacerbations, et de nouveaux algorithmes visant à assurer que les patients reçoivent une thérapie adéquate et appropriée selon la gravité de leur maladie.

Critical Care Outreach
A Demand for Respiratory Therapy Services in Critical Care Outreach at a Large, Tertiary Care Centre
Andria Darlington BSc, RRT

Abstract

Background: As hospitals throughout Canada introduce critical care outreach (CCO) teams in an effort to reduce in-hospital mortality rates, many have concerns regarding whether an effective team structure involves the inclusion of a Respiratory Therapist (RT). The Ottawa Hospital’s General and Civic Campuses were front-runners in a CCO pilot project that included a respiratory therapist on the CCO team.

Objective: This study was conducted to evaluate the need for Respiratory Therapist participation on a CCO team at a large, tertiary care centre.

Method: This study employed a nonexperimental, descriptive research methodology. The study sample was obtained from CCO initial calls and follow-up calls at The Ottawa Hospital, General and Civic Campuses, between January 2005 and August 2006. Demand was measured by respiratory related CCO call diagnoses and respiratory therapeutic interventions performed by CCO. Data was collected with a structured observational method utilizing a checklist for therapeutic interventions and employing biophysical measures to aid the team in determining call diagnoses.

Results: Respiratory failure was the most common CCO call diagnoses at both the General and Civic Campuses. At CCO initial calls, respiratory therapeutic interventions were required in 67% and 77% of initial calls at the General and Civic Campus respectively.

Conclusions: The results suggest there is a demand for respiratory critical care expertise in CCO. To reduce an unnecessary delay in respiratory critical care, CCO teams in similar institutions could include a respiratory therapist.

Introduction

Critical Care Outreach (CCO) is a multidisciplinary team that provides early, aggressive, and adequate resuscitation of unstable ward patients through direct and timely access to critical care specialists in an effort to reduce in-hospital mortality.1

The concept of CCO was conceived in Australia in 1990. The development of CCO stemmed from a financially strained health care system, increasing patient acuity, and limited bed space.2 A resultant delay in patient care led to clinical deterioration of ward patients and prolongation of hospital stay which perpetuated the strain on the system. Thus, there was an identified need for extending critical care services beyond the confines of the intensive care unit (ICU), to the general wards. The development of CCO was supported by the finding that despite medical advancements and a plethora of related resources, the mortality rate of hospital ward patients who sustain a cardiopulmonary arrest has not changed markedly in 30 years.3 Schein et al (1990) determined that 84% of patients show evidence of identifiable physiological deterioration (eg. alterations in breathing patterns, pulse rate, and level of consciousness) eight hours preceding cardiopulmonary arrest. These findings support the need for early recognition of the signs of deterioration of ward patients and an immediate response by critical care clinicians in the prevention of in-hospital cardiopulmonary arrest.

Critical Care Outreach has since become well accepted in Australia and the United Kingdom (UK). With the implementation of CCO, there is evidence of a reduction of cardiopulmonary arrests, unanticipated ICU admissions, non-do-not-resuscitate (DNR) deaths, ICU readmissions, and improved survival rates before discharge. Based on positive outcomes, the American Institute for Healthcare Improvement and the Canadian Safer Healthcare Now! has identified CCO as one of six initiatives of the 100,000 Lives Campaign proven to reduce preventable hospital mortality.

With the demonstrated efficacy of these teams and the campaign underway, North American hospitals are faced with the task of developing an effective CCO team. Part of the planning phase involves determining the best team composition. In referring to the Australian and UK models, administrators should be mindful of the differing health care systems. Notably, in Australia and the UK,
respiratory scientists, nurse specialists, physiotherapists, and other health professionals often perform what would typically be the role of the RT in North America.

Respiratory therapists assist physicians with the diagnosis and treatment of pulmonary disorders. The Ottawa Hospital (General and Civic campuses) is a 1,000 bed tertiary care centre with approximately 50,000 admissions per year. The Ottawa Hospital has participated in a CCO pilot project in which the team composition included a critical care RT. The role of the CCO RT is to perform patient assessments, provide diagnostic and therapeutic respiratory services including advanced life support, and to communicate concerns and results to the patient’s attending team as well as other members of CCO. The CCO RT is also expected to work collaboratively to promote educational opportunities, research, and best clinical practices.

This study examined nineteen months of CCO data at The Ottawa Hospital to determine if there is a demand for respiratory therapists as members of CCO at similar institutions.

**Methods**

A nonexperimental descriptive design was employed to assess the demand for a respiratory therapist on the CCO team. Demand was determined by the frequency of respiratory failure as a CCO call diagnosis and the frequency of respiratory therapeutic interventions performed by CCO. Respiratory interventions included oxygen therapy, continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BiPAP), endotracheal intubation, tracheal suctioning, tracheotomy tube change, and bronchodilator administration.

The study sample consisted of all CCO initial calls and follow-up calls at The Ottawa Hospital, General and Civic campuses, between January 2005 and August 2006. The CCO response was activated by a call made by any ward healthcare professional. The calling criteria included any acute changes in airway, breathing, circulation, neurological status, urine output, or any other serious concern about the patient (Figure 1).

From 0700 hours to 1900 hours, the CCO team was composed of an intensivist, a critical care nurse, and a critical care RT. From 1900 hours to 0700 hours, the CCO team was composed of the on-call ICU residents as well as a critical care nurse. Due to insufficient funding, there is no CCO

### Table 1. CCO Call Diagnoses at the General Campus

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Frequency</th>
<th>Percentage of Total</th>
<th>Diagnosis</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial Infarction</td>
<td>15</td>
<td>5.6</td>
<td>Respiratory Failure</td>
<td>22</td>
<td>13.6</td>
</tr>
<tr>
<td>Arrhythmias</td>
<td>14</td>
<td>4.5</td>
<td>Pneumonia</td>
<td>10</td>
<td>6.0</td>
</tr>
<tr>
<td>SVT/VVT</td>
<td>18</td>
<td>7.6</td>
<td>Atelectasis</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>CHF</td>
<td>4</td>
<td>1.7</td>
<td>OSA</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Pulmonary Edema</td>
<td>7</td>
<td>2.9</td>
<td>Airway Obstruction</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Pericardial Tamponade</td>
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<td>0.4</td>
<td>COPD Exacerbation</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Cerebral Edema</td>
<td>1</td>
<td>0.4</td>
<td>Desaturation</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>Acneutism/Synechiae</td>
<td>2</td>
<td>0.8</td>
<td>Asthma</td>
<td>2</td>
<td>0.8</td>
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<tr>
<td>Decreased LOC NTD</td>
<td>4</td>
<td>1.7</td>
<td>GI Bleed</td>
<td>5</td>
<td>2.1</td>
</tr>
<tr>
<td>CVA</td>
<td>6</td>
<td>2.6</td>
<td>Ischemic Stroke</td>
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<td>0.9</td>
</tr>
<tr>
<td>Sepsis</td>
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<td>1.7</td>
<td>Perforated Viscus</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Opioid/Sedatore Overdose</td>
<td>10</td>
<td>4.2</td>
<td>Surgical Bleed</td>
<td>7</td>
<td>2.9</td>
</tr>
<tr>
<td>Allergic Drug Reaction</td>
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<td>1.7</td>
<td>Bladder Hemorrhage</td>
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<td>0.4</td>
</tr>
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<td>Renal Failure</td>
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<td>Retropertoneal Bleed</td>
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<td>0.4</td>
</tr>
<tr>
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<td>Hypotension</td>
<td>12</td>
<td>5.1</td>
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<td>DKA</td>
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<td>Hypoglycemia</td>
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<td>0.8</td>
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<td>1.7</td>
<td>Hypertension</td>
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<td>1.7</td>
</tr>
<tr>
<td>Pulmonary Embolus</td>
<td>5</td>
<td>2.1</td>
<td>Hypoxemia</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Malignant Effusions</td>
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<td>2.1</td>
<td>Dehydration</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Leukemia</td>
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<td>0.4</td>
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<td>1.7</td>
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<td>TTP</td>
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<td>0.4</td>
<td>Epidural Hypotension</td>
<td>2</td>
<td>0.9</td>
</tr>
</tbody>
</table>

N = 235

Table 1. A frequency distribution of all CCO call diagnoses encountered at the General Campus of The Ottawa Hospital from January 2005 until August 2006.
Special interest

RT during these hours. Ward RTs would receive CCO pages and respond to the call. Patients were seen on a follow-up basis for a minimum of 48 hours following the initial call and a minimum of 48 hours following ICU discharge. If CCO had unresolved concerns, the patients were seen on a follow-up basis beyond the 48 hours.

Data was collected with a structured observational method utilizing a checklist for therapeutic interventions and employing biophysical measures to aid the team in determining call diagnoses. The call diagnosis was determined at initial calls. Data was collected at every initial call and follow-up visits. Data was collected by any of the three members of the CCO team. All CCO members were trained in proper documentation.

Table 2. CCO Call Diagnoses at the Civic Campus

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Frequency</th>
<th>Percentage of Total</th>
<th>Diagnosis</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial Infarction</td>
<td>20</td>
<td>6.6</td>
<td>Respiratory Failure</td>
<td>21</td>
<td>9.0</td>
</tr>
<tr>
<td>Angina</td>
<td>6</td>
<td>1.2</td>
<td>Pneumonia</td>
<td>18</td>
<td>7.7</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>10</td>
<td>4.3</td>
<td>Atelectasis</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Bradycardia</td>
<td>6</td>
<td>2.5</td>
<td>OSA</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>SVT</td>
<td>3</td>
<td>1.2</td>
<td>Airway Obstruction</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>CHF</td>
<td>9</td>
<td>3.8</td>
<td>COPD Exacerbation</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Pulmonary Edema</td>
<td>8</td>
<td>3.4</td>
<td>Desaturation</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Decreased LOC</td>
<td>4</td>
<td>1.7</td>
<td>GI Bleed</td>
<td>10</td>
<td>4.3</td>
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<tr>
<td>Decreased LOC</td>
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<td>0.8</td>
<td>Ischemic Cyt</td>
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<td>0.4</td>
</tr>
<tr>
<td>CVA</td>
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<td>6.0</td>
<td>Perforated Viscus</td>
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<td>0.4</td>
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<tr>
<td>Seizure</td>
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<td>AAA</td>
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<td>0.4</td>
</tr>
<tr>
<td>Hydrocephalus</td>
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<td>0.4</td>
<td>Trauma</td>
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<tr>
<td>Constipation</td>
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<td>Surgical Bleed</td>
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<td>2.1</td>
</tr>
<tr>
<td>Cerebral Edema</td>
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<td>1.2</td>
<td>Hypotension</td>
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<td>Agitation</td>
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<td>Hypovolemia</td>
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<td>Opioid/Sedative Overdose</td>
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<td>Hypoglycemia</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Allergic Drug Reaction</td>
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<td>1.2</td>
<td>Hypercalcemia</td>
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<td>2.1</td>
</tr>
<tr>
<td>Poor Pain Control</td>
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<td>Dehydration</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>1</td>
<td>0.4</td>
<td>Pulmonary Embolus</td>
<td>7</td>
<td>3.0</td>
</tr>
<tr>
<td>Liver Failure</td>
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<td>0.8</td>
<td>Malignant Effusions</td>
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<td>0.8</td>
</tr>
<tr>
<td>Sepsis</td>
<td>11</td>
<td>4.7</td>
<td>Retroperitoneal Bleed</td>
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<td>0.4</td>
</tr>
</tbody>
</table>

N = 231

Table 2. A frequency distribution of CCO call diagnoses encountered at the Civic Campus of The Ottawa Hospital from January 2005 until August 2006.

Results

At the General Campus, there were 326 initial CCO visits and 230 follow-up visits. Respiratory failure was the most commonly encountered CCO call diagnosis (Table 1). At the General Campus, a total of 231 initial visits required respiratory therapeutic interventions out of 346 initial visits (67%) (Table 3). A total of 21 follow-up visits required respiratory therapeutic interventions out of 230 follow-up visits (9%) (Table 3). Respiratory assessments were not included in the tabulation of interventions. If patients required more than one respiratory intervention, each intervention was included in the tabulation. At the Civic Campus, there were 385 initial CCO visits and 828 follow-up visits. Respiratory failure was the most commonly encountered CCO call diagnosis (Table 2). At the Civic Campus, a total of 295 initial visits required respiratory therapeutic interventions out of 385 initial visits (77%) (Table 4). A total of 80 follow-up visits required respiratory therapeutic interventions out of 828 follow-up visits (10%) (Table 4). Assessments were not included in the tabulation of interventions. If patients required more than one respiratory intervention, each intervention was included in the tabulation.

Discussion

This study showed that in 19 months of CCO, respiratory failure was the most common call diagnoses at both the General and Civic Campuses and was more frequently encountered than sepsis, myocardial infarction, and tachyarrhythmias. Several calls that did not document respiratory failure as the primary call diagnoses had altered respiratory function which was identified as pneumonia, atelectasis, obstructive sleep apnea, airway obstruction, chronic obstructive pulmonary disease exacerbation, and desaturations. Schein et al (1990) found that pathophysiologic alterations in respiratory status comprised the majority of all clinical antecedents to in-hospital cardiopulmonary arrests. In related research, Hodgetts et al (2002) identified abnormal breath rate or shortness of breath as an independent predictor of cardiac arrest. These studies support the notion that deterioration in respiratory status warrants early recognition and immediate, aggressive treatment. These findings...
suggest that if the most common diagnoses encountered by CCO are respiratory related, these teams should offer direct and timely access to respiratory care expertise as provided by respiratory therapists.

This study also demonstrated that the majority of CCO patients required respiratory interventions on their first visit by CCO, 67% and 77% at the General and Civic Campuses respectively. These findings further support the need for the CCO team to include someone with the respiratory critical care expertise to treat these patients. The Institute for Healthcare Improvement (IHI) and Safer Healthcare Now! (SHN) suggest four successful models of CCO team composition, all of which include a respiratory therapist[6,7]. The IHI and SHN then outlines the features all models should possess including their availability to respond immediately without being constrained by other competing workloads, to be onsite and accessible, and to possess the necessary critical care skills to assess and respond[6,7].

This study is limited in that it did not capture all possible diagnostic and therapeutic interventions performed by CCO. Other frequently performed RT duties include arterial blood gases, bedside spirometry, mechanical ventilation initiation and management, passy-muir valve counseling and care, lung volume recruitment maneuvers (breathstacking and insufflation/exsufflation), formulating goal-directed plans for tracheotomy patients and mechanically ventilated patients, electrocardiograms, transfers of critical patients, and medical gas administration. These are interventions often indicated at CCO visits, all within the scope of practice of a respiratory therapist.

The exclusion of an RT in CCO may be associated with a delay in necessary care. There may be a prolonged respiratory therapist response time. Without an RT dedicated to the CCO team, the RT would have to prioritize other patient care responsibilities which may or may not allow the RT to respond immediately. Therefore, this model may not offer necessary critical care that is directly onsite and accessible and free from the constraints of competing workloads. These are the challenges CCO faces at The Ottawa Hospital during the hours of 1900–0700. Other research shows that patients resuscitated between 2301hr and 0700hr are at a significantly higher risk of not being discharged home than those resuscitated between 0701hr and 1500hr[10].

Perhaps this isn’t the time to spread resources thinly. Could including a dedicated respiratory therapist to the CCO team improve outcomes data for CCO?

Without the inclusion of a CCO RT, respiratory services may be provided by a member of the CCO team with comparatively less respiratory

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<tr>
<th>Table 3. Respiratory Therapeutic Interventions at the General Campus</th>
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<td><strong>Initial Visits (N = 346)</strong></td>
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<td>Tracheal Suctioning</td>
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<td>Tracheotomy Tube Change</td>
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<td>Bronchodilator Administration</td>
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<td>Assessment</td>
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**Table 3.** A frequency distribution of respiratory therapeutic interventions performed by CCO at the General Campus of The Ottawa Hospital from January 2005 to August 2006.

<table>
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<th>Table 4. Respiratory Therapeutic Interventions at the Civic Campus</th>
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<td>Assessment</td>
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**Table 4.** A frequency distribution of respiratory therapeutic interventions performed by CCO at the Civic Campus of The Ottawa Hospital from January 2005 to August 2006.
experts than that of an RT. Having an RT on the team to conduct immediate respiratory assessments may allow a more comprehensive and thorough assessment of the patient by CCO.

Conclusion
Based on CCO call diagnoses and CCO interventions, this study suggests there is a demand for respiratory care expertise in CCO at The Ottawa Hospital. Future research could compare outcomes data of CCO teams employing RTs versus other models of similar organizations. Similar hospitals are encouraged to include individuals with respiratory therapy expertise, such as respiratory therapists, in CCO and by doing so, align the CCO patient with truly accessible, on-site, and rapidly responding respiratory critical care.

References
6. Institute for Healthcare Improvement www.ghi.org/programs/campaign
7. Safer Healthcare Now! www.saferhealthcarenow.ca
8. Canadian Society of Respiratory Therapists www.csrt.com/about
Rapport du Comité de défense des intérêts sur la Semaine de la TR

Suite de la page 5

public, ce genre d’initiative s’adresse également à vos collègues à la recherche de renseignements supplémentaires!

La SCTR reçoit souvent des demandes d’assistance pour le montage de kiosques et de démonstrations dans des centres de sciences provinciaux, des musées et d’autres endroits. Puisque plusieurs de ces démonstrations exigent des mois de préparation, IL N’EST JAMAIS TÔT POUR COMMENCER!

La Semaine de la TR est une occasion idéale pour promouvoir notre profession et éduquer les gens autour de nous. Qu’il s’agisse d’installer un kiosque dans le centre d’achats local, de monter une exposition dans un stade/arène, ou de communiquer avec les médias locaux, notre but est de renseigner le public sur l’importance de ce que nous faisons. Le Comité de défense des intérêts est là pour vous aider avec vos initiatives futures. N’hésitez pas à nous joindre pour obtenir des idées liées à des endroits ou à des activités éventuelles, des suggestions à savoir comment impliquer vos collègues ou simplement pour tester vos idées. Communiquez avec nous par courriel à rtweek@csrt.com ou au bureau de la SCTR au 1-800-267-3422 pour un complément d’information à savoir comment VOUS impliquer!
Abstracts

Effect of prolonged and exclusive breast feeding on risk of allergy and asthma: cluster randomised trial

Michael S Kramer, James McGill professor, and scientific director1, Lidia Matush, chief2, Irina Vanilovich, senior scientist2, Robert Platt, associate professor, and investigator and associate director3, Natalia Bogdanovich, senior scientist3, Zinaida Sekvovskaya, senior scientist3, Irina Dzikovich, senior scientist3, Gyorgy Shishko, director4, Bruce Mazer, associate professor, and head2, for the Promotion of Breastfeeding Intervention Trial (PRO-BIT) Study Group

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Objective: To assess whether exclusive and prolonged breast feeding reduces the risk of childhood asthma and allergy by age 6.5 years.

Design: Cluster randomised trial.

Setting 31 Belarussian maternity hospitals and their affiliated polyclinics.

Participants: A total of 17,046 mother-infant pairs were enrolled, of whom 13,889 (81.5%) were followed up at age 6.5 years.


Main outcome measures: International study of asthma and allergies in childhood (ISAAC) questionnaire and skin prick tests of five inhalant antigens.

Results: The experimental intervention led to a large increase in exclusive breast feeding at 3 months (44.3% v 6.4%; P<0.001) and a significantly higher prevalence of any breast feeding at all ages up to and including 12 months. The experimental group had no reduction in risks of allergic symptoms and diagnoses or positive skin prick tests. In fact, after exclusion of six sites (three experimental and three control) with suspiciously high rates of positive skin prick tests, risks were significantly increased in the experimental group for four of the five antigens.

Conclusions: These results do not support a protective effect of prolonged and exclusive breast feeding on asthma or allergy.

Trial registration: Current Controlled Trials ISRCTN37687716


Standardization of the Single-Breath Diffusing Capacity in a Multicenter Clinical Trial*

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* From the Johns Hopkins University School of Medicine (Dr. Wise), Baltimore, MD; Pfizer Global Research and Development (Drs. Teeter, England, Schwartz, and Riese), New London, CT; LDS Hospital and University of Utah (Drs. Jensen and Crapo), Salt Lake City, UT; Ferraris Respiratory (Mr. Giles), Louisville, CO; University of Iowa Carver College of Medicine (Dr. Ahrens), Iowa City, IA; and Duke University Medical Center (Dr. MacIntyre), Durham, NC.

Correspondence to: Robert A. Wise, MD, FCCP Johns Hopkins Asthma & Allergy Center, 5501 Hopkins Bayview Circle, Baltimore, MD 21224; e-mail: rwise@jhmi.edu

Background: Standardization of the measurement of single-breath diffusing capacity of the lung for carbon monoxide (DLCO) is difficult to implement in multicenter trials as differences in equipment, training, and performance guidelines have led to high variability between and within centers. The safety assessment of inhalable insulin required the standardization of measurement of single-breath DLCO in multicenter clinical trials to optimize test precision.

Methods: This was an open-label, 24-week, parallel-group, outpatient study of inhaled human insulin in participants with type 1 diabetes who were randomly assigned to receive treatment with daily premeal inhaled or subcutaneous (SC) insulin for 12 weeks, followed by SC insulin for 12 weeks. Monitoring of single-breath DLCO using standardized methodology was performed. Standardization included uniform instrumentation, centrally trained study coordinators, and centralized data monitoring and review of quality control. Sites received feedback within 24 h for any tests of unacceptable quality with recommendations for improvement.

Results: A total of 226 study participants at 33 sites completed 11,335 DLCO efforts during 4,797 test sessions; 3,607 (75.2%) and 4,581 (95.5%) of all testing sessions yielded two American Thoracic Society-acceptable efforts that varied by < 1 and 2 mL/min/mm Hg, respectively. Only 65 sessions produced one or fewer acceptable efforts. The root mean square intrasubject coefficient of variation in DLCO at the end of the comparative dosing phase was 6.01%.

Conclusions: The standardized methodology employed in this study demonstrates the feasibility of collecting high-quality single-breath DLCO data in the setting of a multicenter clinical trial with reliability that is comparable to spirometry.

Key Words: clinical trials • diffusing capacity • inhaled human insulin • methodology • respiratory function tests

**Part Two: Medical Simulation**

How to build a successful and long-lasting program.

P.G. Brindley MD FRCPC,1,2,3 G. I. Suen MD FRCPC,2 J. Drummond RRT,2

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**Introduction**

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**Acknowledgements:** To the Respiratory Therapists of the Capital Health Region, Alberta for your dedication and caring.

**Key words:** Medical education • medical simulation • communication skills • crisis resource management

**Conflicts on interest:** None. Dr. Brindley is the Medical Lead for Patient Simulation for Capital Health, Alberta and Vice-president for the non-profit Canadian Resuscitation Institute.

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**Simulation Versus Simulators**

It must be emphasized that the Simulator (i.e. the task-trainer, computer or mannequin) is only a small part of the Simulation (i.e. the full experience of immersion in a simulated environment). In other words, optimal simulation represents a technique, not a technology. Simulation requires a realistic setting (the area used to represent the clinical environment); candidates willing to suspend disbelief (see below); able facilitators (actors realistically portraying Doctors, Nurses, Respiratory Therapists and others) and skilled debriefers (experts in the clinical content; experts in principles of Crisis Resource Management (CRM); and experts in giving feedback.) In short, it is easy to understand the rationale for simulation. It is also comparatively easy to secure one time funding to purchase a simulator or even to build a centre. However, it is much harder to deliver and maintain effective Medical Simulation programs. Millions of dollars have been wasted assuming otherwise.

Hospitals and educators-alike must determine if they truly are committed to providing adequate long-term funds and resources and to listening to what learners want, and educators need. Otherwise programs traditionally last less than a year, or as long as people are prepared to give up their time without recognition or remuneration. Good-will and enthusiasm are not simply enough. Instead of establishing and maintaining your own program, the option also exists to avoid capital and maintenance costs and instead contract out to recognized experts and regional simulation centres. For example, simple economics suggest that fifty thousand dollars (the cost of an average high-
fidelity simulator) can either be invested in capital purchase or to paying others to provide numerous hours of education. With the first option no simulation has actually been delivered, in the second logistics are minimized.

Planning for Long Term Success
Numerous “champions” are also essential: whether as clinical experts; renowned teachers; enthusiastic administrators eager to innovate; or those passionate about Patient Safety. Simulation is potentially a large enough portfolio that it should not always be an additional task from an already busy clinician, educator or administrator. Again, without these insights, experience suggests that programs typically last about a year. Furthermore, lessons have been learnt by each centre that has started a program, and considerable expertise now exists in terms of matching the educational goal with the right simulation strategy. For example, initially, many programs wish to use a single simulator to teach all things. Unfortunately this prematurely wears-out the mannequin, and if the simulator is not the ideal platform it can actually distract from the educational goal. Without seeking the insights of others there is ever likelihood that the same mistakes will be repeated.

Wide-ranging support is also essential. For example, Simulation is not just relevant for those interested in education - you should also target those concerned with safety, staff-retention, rural-outreach, even research. The wider the interest group is, the greater the opportunities for collaboration and shared funding. Equally, it is very easy to unintentionally give the impression that those who teach traditionally, or were not trained using Simulation, that they are somehow out-of-date. Not only is that specious, it is also disastrous for your Simulation Program. Only following the above caveats is it appropriate to discuss the Simulators themselves.


Task Trainers
Task trainers reproduce only one aspect of the required skill. By breaking down a larger task into its component subtasks, students learn even complex skills in a controlled and timely fashion. Task trainers are commonly used to teach procedural skills such as central venous cannulation, endotracheal intubation, and aspiration of joints. Beaubien and Baker suggest using “task trainers to train teamwork related skills to the point of over-learning.” Task trainers tend to be much less time-consuming than full mission simulators, thus allowing learners to repetitively practice certain skills until mastery occurs. They are also less-expensive which permits purchase of multiple units. The relative lack of mechanical parts means they typically require less maintenance, and are more robust and portable. This allows task trainers to be lent-out easier or be taken directly to the learner. Learners can often use these task trainers in a semi-independent fashion. This means trainees can learn at their own pace, and busy facilitators do not always need to be present.

Task trainers with haptic (touch) feedback are increasingly being used to teach procedural skills. These systems “create the illusion that the operator is coming into physical contact with the model”. For example, a colonoscopy simulator with haptic feedback actually provides the student with varying degrees of resistance while the endoscope is navigated through the colon depending on the simulated patient’s anatomy. For example, when learning the lumbar puncture, a haptic system can simulate the “pop” that indicates successfully locating the spinal space.

Computer Based Systems
Computer based systems focus more on individual decision-making and judgment as compared to the manual dexterity aspects of a task trainer. They typically involve watching a television screen, and as such, there is typically little need to simulate the whole clinical environment. Psychologically, however, they can be useful if the scenarios are engaging. Multiple examples of web-based resuscitation scenarios exist and typically involve resuscitating a patient by applying principles taught in an advanced life support course. Learners are given a variety of choices and are scored on appropriateness and speed of response. However, working alone, being seated behind a computer terminal, and merely clicking on a computer button which states, for example, “intubate patient” is far different than performing for real. However, computer based systems can be a cost-effective way to provide simulation to large groups. They can promote clinical judgment, and can address preliminary Crisis Resource Management (CRM) proficiencies such as the need for situational awareness and pre-emptive treatment. However, they really do not address CRM proficiencies such as communication or teamwork. As computer technology advances, this type of simulation may become even more useful and more portable. For example, Issenberg et al. described the introduction of virtual reality (VR) simulators such as the “PreOp endoscopic simulator”. This VR
Scientific news

Full Mission Simulators

Full-mission simulators aim to achieve an immersive experience for the learner by ensuring that equipment, environmental, and psychological realism are maximized. The classic example is the multi-million dollar flight simulators used to train pilots where cockpits are almost indistinguishable from reality and hydraulic machines simulate the physical characteristics of flight. Teamwork and CRM skills can be practiced in a fashion that is not feasible with task trainers or computer-based systems. Beaubin and Baker therefore recommend using full mission simulators to "hone teamwork related skills under conditions of ambiguity, time pressure, and stress." The obvious use of full mission simulators in health care is to simulate the full resuscitation of critically ill patients, and to highlight CRM.

“Perfect is often the enemy of good”

The primary disadvantages of full mission simulators are their higher costs and lower portability. The more sophisticated the simulator, the easier they can malfunction, the greater the reluctance to allow them to leave the Simulation Centre, and the greater the need for dedicated facilities and trained personnel. As such, expertise is needed to determine which platform offers the most blend of realism, portability and practicality, and cost-effectiveness. As such, Simulation Experts can be indispensable.

A full-body, high-fidelity simulator might be wasted on students who are learning routine tasks e.g. arterial line insertion. In contrast, healthcare workers may wish a highly realistic setting incorporating the latest simulator technology to learn how to function in an evolving crisis. Full-mission medical simulators, such as the Laerdal SimMan® and METI ECS® offer the advantages of increased anatomic and physiologic reality with the ability to be packaged in a crate. As such, these two models are the most common for teaching acute care resuscitation.

Portability is extremely important. For example, whenever possible the simulator should be taken to the learner rather than expecting learners to come to a central teaching site. With busy schedules it is often impractical to expect healthcare workers to travel across town, let alone devote several days and invest the cost of travel and hotels. With this in mind the classrooms of the future should be flexible enough to be simulation-compatible. Furthermore, portable simulators, appropriately, dominate the market even if this means occasionally sacrificing realism.

Simulation Fidelity

Fidelity refers to "the degree to which the simulator replicates reality." Studies have shown that with higher fidelity simulators are associated with higher percentages of students having a favorable response to the simulation experience. Many trainees' first impressions and willingness to undergo Simulation training depend upon how realistic the simulator looks as compared with a real patient.

Other tools in the room such as a laryngoscope or realistically packaged medications also help to ensure a high-fidelity situation. These types of considerations are known as equipment fidelity. Environmental fidelity is also an important consideration as simulations performed in a classroom may be quite different when performed in the middle of a busy emergency department trauma bay, or the tight confines of a patient room. In fact, this is one way in which "dry-runs" using simulators can actually help with the design of optimal medical treatment areas. It is also how Simulators can be used to train healthcare workers to deliver care in suboptimal environments. It is, again, why simulators should ideally be portable enough to be taken to the same area where the trainees will ultimately deliver care.

Example of a Computer-Based Simulator with Tactile (Haptic) Feedback: Xitact ITP — Instrument Tracking Port™ www.xitact.com

Example of a Full Mission Simulator: the METI Human Patient Simulator™ www.meti.com
Interestingly, however, the most important type of fidelity may be psychological fidelity. Students must “temporarily suspend disbelief and interact much as they would in the real world”. Without psychological fidelity, equipment and environmental fidelity appear to be of limited utility. Again, it argues that simulation experts can offer unique insights.

Program Development
Several examples of successful simulation programs will be outlined in part-three of this series. However, in the most comprehensive systemic review to date of this topic, Issenberg et al. reviewed 670 articles found ten key features of high fidelity simulations associated with effective learning. These were 1. providing feedback, 2. repetitive practice, 3. curriculum integration, 4. range of difficulty level, 5. multiple learning strategies, 6. capturing clinical variation, 7. a controlled environment, 8. individualized learning, 9. defined outcomes, and 10. simulator validity. In-depth discussion of each factor is beyond the scope of this paper, but their work clearly illustrates the presence of a large body of literature devoted to the theoretical principles and features of successful simulation. Those committed to simulation delivery need to follow this literature.

Instructors can be responsible for keeping lists of clinical events which can include “high-risk situations”, “near misses” and “unfortunate outcomes”. Educational experts and clinical content experts can readily turn these into simulation scenarios. However, it should be emphasized that education should also be about practicing when things go right. Good outcomes are, after all, our ultimate clinical goal. This approach also helps decrease the common misconception that Simulation is merely punitive.

Summary
Initial purchase of a simulator is a minor part of establishing a simulation program. Viable programs require widespread support, ongoing funding, and champions in the clinical, educational and administrative sphere. Simulators are typically divided into task-trainers, computer-based systems, and full mission simulators. An appreciation of simulator fidelity includes not only assessing which simulator is most appropriate, but how to arrange the environment, and encourage the participants. Unfortunately, failure to recognize these many factors has been both widespread and costly. This manuscript is intended to offer constructive solutions and to promote the effectiveness and longevity of Medical Simulation programs.

References
Respiratory Therapy is currently accepting applications for a full time Staff Respiratory Therapist — two positions.

Under the general direction of the Diagnostic Services, Program Manager, the successful incumbent will work closely with hospital staff and provide knowledge and advise in therapeutic/diagnostic principles and technical skills. The Respiratory Therapist also sets up, operates and assesses proper application of respiratory therapy equipment, making modifications as required assuring patient safety and optimum possible care.

The successful candidate will possess the following qualifications:

**REQUIRED QUALIFICATIONS:**
- Currently licensed with Manitoba Association of Registered Respiratory Therapists.
- Must have an extensive knowledge of each area of the department, both in procedures and techniques in order to operate area, assist in area, and analyze technical procedures and problems in each area.
- Must have special ability and knowledge in Quality Control and standards of Respiratory Care, exhibited qualities of leadership, teaching and self-improvement. Must be able to provide input and planning in a clinical setting.
- Must have computer knowledge.
- Current BSLC and BCLS Instructor Certificate within the past 12 months.
- Ability to respect and promote confidentiality.

**DESIRABLE QUALIFICATIONS:**
- Must have ability to get along with people and to cooperate with other staff members.
- Must possess organizational ability.
- Must be willing to follow instructions and proper lines of communication.
- Must possess desire to further knowledge relating to the work involved in order to accomplish job description.
- Certified in Advanced Cardiac Life Support, Pediatric Advanced Life Support or Neonatal Resuscitation.

The successful candidate will be subject to a Criminal Records and a Child Abuse Registry Check and will be responsible for any service charges incurred.

Applicants should forward a confidential resume with references to:

Human Resources Department
Brandon Regional Health Authority
150 McTavish Avenue East
Brandon MB R7A 2B3
Ph: (204) 578-4760 Fax: (204) 578-4937
E-Mail: humanresources@brandonrha.mb.ca

For more information and a list of other employment opportunities with the Brandon RHA, please visit our website at www.brandonrha.mb.ca
Intubation Positions

Part 2 of 2

Rick Paradis RRT, B Adms.; Charge Therapist, O.R.; Respiratory Therapy Department / Anesthesia; Mount Sinai Hospital

This is the second article that will discuss the various intubation positions and some of the rationale and physical limitations with each technique. Though these techniques are not common, they may be required in challenging situations and now you can be ready to take on that challenge with practice.

Kneeling Intubation Position

This position is not used too often and requires that you have a good back, hips and knees. Basically you are kneeling and then crouching forward so that your back is bent. This position looks like the fetal position. If you have lower back pain or have injured knees or hips, then this technique will not work.

Therapists have asked me when would I ever use this position and my answer is hopefully never! This is an awkward situation but one in which you should be prepared for. Consider this position if for some reason you cannot extend too far past the patient’s head, in other words you cannot lie on your stomach. With an obstruction near the patient’s head, this becomes one possible intubation solution.

Consider the situation of a pregnant RT trying to use this intubation technique. It would be a greater challenge to achieve the fetal position described above for obvious reasons and therefore potentially affect her line of sight.

One very important bit of advice that can be offered to anyone doing an intubation is this: once you finally see the vocal cords — do not take your eyes off of the cords!!! Ask your assistant to place the endotracheal tube in your hand. Then finish the intubation by watching the cuff pass the cords. Now confirm placement by auscultation or EtCO2.

For the purpose of the Airway Olympics, there is no need to inflate the cuff. Tube placement is confirmed when the resuscitation bag is attached to the ETT and both lungs inflate. One lung is not good enough because that signifies a right main-stem intubation which is common during this competition when the adrenalin is going and the tube is “shoved in”.

Creating a Sniff Position on the Ground

This is a scenario that you would not normally see. It is also a situation where you are sure that the patient has no neck injury at all. This scenario requires that you position your patient in the sniff position when you have no pillows or anything to lift the head.

Simply lift the patient’s head gently onto your shin. It does not matter which shin, simply choose the position that is most comfortable for you. Again you will notice that there could be limitations if you have a bad knee, hip, back or neck. Using the sniff position will help your line of sight to view the cords.
La conférence annuelle de l’AARC a également lieu à l’automne, de même que la réunion du Conseil international pour les soins respiratoires. Le président de la SCTR et moi-même, en qualité d’administrateur pour le Canada et de trésorier, assistons à cette réunion.

Il s’agira d’une réunion importante pour la SCTR cette année puisque nous présenterons un compte rendu de nos activités avec l’ANORTR en matière de reconnaissance des titres de compétences internationaux et nous déposerons un rapport du groupe de travail de la SCTR sur l’agrément international. Des renseignements additionnels sur les activités du groupe de travail, y compris un rapport sur sa visite récente à Qatar, sont publiés dans ce numéro.

Le numéro d’hiver fournit la première occasion de publier les grandes lignes de la prochaine conférence nationale à Saskatoon. Prévoyez dès maintenant de participer à cette activité à ne pas manquer.

Ce numéro renferme d’excellents articles, y compris la deuxième partie d’une soumission traitant des positions d’intubation, rédigée par notre maître des Olympiades des voies aériennes, Rick Paradis. Qui de mieux pour traiter de ce sujet que celui qui établit si bien le rythme effréné pour les participants aux Olympiades! Tous ceux qui cherchent un avantage à la prochaine compétition des Olympiades des voies aériennes ont intérêt à lire son article attentivement.


Doug Maynard TRA, MBA
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Icepick Intubation Position

This style of intubation works very nicely for reasons that I will mention in a moment.

The hardest part about this intubation is that the airway view is upside down and the equipment is held backwards. The technique is to pull instead of lift the laryngoscope. Other than that, it is simple! This is a skill that definitely requires practice, but once you understand the concept and how the anatomy will look, it becomes very easy. I have seen this technique performed in 15–20 seconds by extremely proficient RTs. Most beginners using this technique will take 2 minutes. During the Airway Olympics we limit it 4 minutes.

So how do you perform the intubation? Simple, place the scope in your right hand instead of your left hand. Turn the handle upside down so that the blade is coming over the top of your hand. Insert the blade and pull the tongue towards you when you get near the vallecula.

The pulling towards you should be easier than with regular intubations because muscles in your back and shoulder are bigger and stronger than your forearm muscles. It will feel like less muscular effort is used to expose the airway.

The next important point is that the endotracheal tube is held in your left hand which most RTs are not used to. Ever try to do a blood gas or IV with your other hand? It is not easy unless you train to be ambidextrous. This fine motor movement may be easier for someone who is left handed.

Finally, note that the RT does not sit on the patient’s chest. Room is given by kneeling with one knee which allows the patient to take a breath if one is attempted.

When will this technique be used? I have seen it used in the ICU for a reintubation of a COPD patient with multiple previous intubations and the patient was not able to lay flat. Instead the patient remained in the sitting position and the Anesthesiologist faced the patient and “Icepicked” the airway: At that time I had no idea that this was even possible.

Paramedics have mentioned to me that this technique could be used if the patient is trapped in a motor vehicle accident and the only way to reach them is through the windshield.

How Not to Do the Icepick Method

Especially during the Icepick maneuver, it should be noted that obstacles that normally dangle from an RT’s neck, such as a stethoscope, ID badge, pen on a lanyard, long hair, etc... will affect your ability to succeed with the intubation. Your view will be obstructed and valuable time will be lost. In addition, there is a danger to the patient’s eyes from items that could scratch the cornea.
Therapists are taught to use the laryngoscope to sweep the tongue out of the way to provide you with an unobstructed view of the cords. Simply use that same logic of “unobstructed view” for items near a patient’s face as mentioned above. This may sound like common sense but I always see someone doing an intubation and being distracted by these extraneous items.

**Closing Thoughts for this Article**

First of all I would like to give a big thank you to Suzy Cioran RRT and Phil Lau RRT for demonstrating these techniques in the pictures above.

Now that you have read about the various intubation positions that many RTs have found themselves in, it is time for you to practice them. There is supine, left or right lateral and the regular position as described in the previous article. Additional positions include kneeling, sitting with your leg under the patient’s head (sniff position) and finally icepick which seems to be the most awkward but is easier once you get your orientation to the anatomy.

Over the years I have noticed a trend with the intubation scoring times. Usually our medical students and junior RT students take the most time simply because they usually have the least amount of experience. New RT grads and anesthesia residents tend to have the next best times, shaving on average 10 seconds off each technique. When the fellows and more seasoned RTs square off, the times improve again by 5–10 seconds. Finally you have the staff anesthesiologists and seasoned RTs who have the most experience and best intubation times.

The fastest time yet recorded is 6 seconds! That was simply incredible.

One scenario that was not mentioned involves an intubation in a confined space for example like a CT scanner. I realize that the patient would be pulled out of the scanner but the concept is to intubate with little or no room to maneuver. It could happen at a motor vehicle accident for example. Paramedics described this scenario to me many years ago. Hopefully you will never need to intubate in a position other than the regular position but a good RT is prepared for anything and able to perform the task at hand.

Now keep practicing and I hope to see many expert airway Olympians at the 2008 CSRT conference in Saskatoon!