College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

Community Respiratory Therapy Practice

PROFESSIONAL PRACTICE GUIDELINE

December 2025

College of Respiratory Therapists of Ontario (CRTO) publications contain practice parameters and standards that should be considered by all Ontario Respiratory Therapists in the care of their patients/clients and in the practice of the profession. CRTO publications are developed in consultation with professional practice leaders and describe current professional expectations. It is important to note that these CRTO publications may be used by the CRTO or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

It is important to note that employers may have policies related to XX care. If an employer's policies are more restrictive than the CRTO's expectations, the RT must abide by the employer's policies. Where an employer's policies are more permissive than the expectations of the CRTO, the RT must adhere to the expectations of the CRTO.

Table of Contents

Introduction

As our population ages and people desire to age in place at home, community respiratory therapy becomes increasingly important. The purpose of this Professional Practice Guideline (PPG) is to support **Respiratory Therapists (RTs)** who work in a community setting, which may include patients' homes, long-term care and congregate living, primary care, and specialist physician practices. Community practice enables RTs to apply their specialized body of Respiratory Therapy knowledge and skills to the treatment and management of a diverse patient population in a range of unique settings. Community practice encompasses the provision of RT services outside of a hospital setting, including, but not limited to:

- chronic disease management, and rehabilitation;
- palliative and end-of-life care;
- complex airway care and ventilation;
- patient education;
- diagnostic testing; and
- pharmaceutical and/or medical equipment education and sales.

RTs who practice in the community often face different opportunities and challenges than their colleagues working in hospitals. A key distinction is the uniquely autonomous nature of community practice, which requires RTs working in that setting to be self-directed and possess a high degree of professional competency. This is because RTs in the community are regularly required to independently make important care decisions and act in accordance with organizational policies and their own personal knowledge and judgement. RTs working in the community are also often responsible for the safe keeping of patients' personal health information and setting their own daily schedules and therefore, must be disciplined and have well established organizational skills.

The fact that community care is often provided in the patient's place of residence and/or over a prolonged period of time alters the nature of the professional relationship. Patients and their families may play a more integral role in directing care in the community, which requires the RT to employ a person-centred care approach to meet the patients' and their families' unique personal situations, needs and goals. Lengthy interactions between the RT and the patient/family member can also make it more challenging to maintain appropriate professional boundaries and avoid such things as interpersonal issues and conflicts of interest.

The information contained in this PPG covers a wide range of topics that relate specifically, although not exclusively, to community RT practice. It is important to note that all RTs, regardless of practice location, are required to maintain and uphold the **Standards of Practice** of the profession established by the CRTO, as well as all relevant legislation and regulations.

Business Practices

Providing care in the community, as opposed to a hospital, brings the business side of healthcare much closer to RT practice. The CRTO Standards of Practice states that "RTs must only engage in business practices that are transparent, ethical, and not misleading to the public." Privacy and confidentiality, security of **Personal Health Information (PHI)** and ethical, evidenced-informed care are essential in all healthcare settings. However, providing RT services in the community may necessitate that other concerns such things as billing and advertising also be taken into consideration. This section on business practices endeavors to clarify how these and other aspects need to be managed in community RT practice.

Privacy and Confidentiality

Federal and provincial legislation protects patients' rights to privacy and confidentiality of their PHI. Therefore, RTs have a legal obligation, as well as a professional and ethical obligation, to ensure that their patients' PHI remains secure and confidential. The following two agencies have been tasked with enforcing this legislation:

1. **Office of the Privacy Commissioner of Canada**

The mission of the Office of the Privacy Commissioner of Canada (OPC) is to protect and promote privacy rights of individuals by enforcing compliance with The Personal Information Protection and Electronic Documents Act (PIPEDA).. This legislation aims to protect the private sector data of Canadians and gives an individual the right to lodge a complaint with the Privacy Commissioner of Canada about any alleged mishandling of their personal information. .

2. **Information and Privacy Commissioner of Ontario**

The Information and Privacy Commissioner of Ontario provide oversight of Ontario's access and privacy laws, which establish the rules for how Ontario's public institutions and health care providers may collect, use, and disclose personal information. The *Personal Health Information Protection Act (PHIPA)* is enforced by the Information and Privacy Commissioner of Ontario and apples to almost all RTs, regardless of where they practice.

Personal Health Information (PHI)

Subject to certain exceptions set out in *PHIPA*, PHI refers to information about an individual in oral or recorded form that relates to the:

- physical or mental health of an individual;
- provision of healthcare to the individual;
- individual's health card number; or
- identification of the individual's substitute decision-maker (if applicable)

Circle of Care

The term "circle of care" is not defined in *PHIPA*. However, the Information and Privacy Commissioner of Ontario states that it is "a term commonly used to describe the ability of certain health information custodians to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances defined in *PHIPA*"[i1]. The circle of care includes the healthcare providers who require specific medical information in order to provide care to a particular patient. In most situations, these healthcare providers may rely on the **implied consent** of a patient to share medical information within the circle of care.

Consent by a patient to share information with providers in the circle of care is generally implied. Therefore, a patient who accepts a referral to another healthcare provider implies consent for sharing relevant information.

For example…

A physician orders home oxygen for a patient and the patient agrees with the physician's plan of care. This means that the patient has given implied consent for the RT(s) who will be providing their oxygen to be part of the circle of care. The RT(s) is, therefore, permitted to access the patient's PHI and share that information within the circle of care.

[1] Information and Privacy Commissioner of Ontario. (August 2015). Circle of Care Sharing Personal Health Information for Health-Care Purposes. Retrieved from https://www.ipc.on.ca/wp-content/uploads/Resources/circle-of-care.pdf

If a patient cannot provide consent, then a **Substitute Decision-Maker** (SDM) becomes part of the circle of care, and can provide consent on the patient's behalf to allow PHI to be shared within the circle of care.

Expressed consent is required to share information with non-custodians outside the circle of care (e.g., family members who are not a guardian or SDM, police, insurance ~~company, etc.)~~

Sharing PHI Outside the Circle of Care

As outlined previously, RTs have a legal and professional obligation to maintain the confidentiality of a patient's PHI. There are circumstances, however, where healthcare professionals are either required or permitted to report particular events or clinical conditions to the appropriate government or regulatory agency. In Canada, provincial, territorial and federal statutory requirements mandate that healthcare providers report to the appropriate agencies when certain conditions apply. RTs who work in the community, particularly those who have established an independent practice, need to be aware of the relevant mandatory reporting requirements. Some examples of circumstances where information either must or can be shared outside the circle of care include:

A Child in Need of Protection

The Ontario Child, Youth and Family Services Act stipulates that it is the law to report suspected child abuse or neglect. Therefore, if an RT has **reasonable grounds** to suspect that a child is or may be in need of protection, they must report it to their local Children's Aid Society (CAS). It is not necessary to be certain a child is or may be in need of protection to make a report to a CAS, and an ~~R~~RT must not rely on anyone else to report on their behalf. Any healthcare professional who fails to report a suspicion is liable on conviction to a fine of up to $5,000, if they obtained the information in the course of their professional duties.

Concerns about a Patient's Fitness to Operate a Motor Vehicle

In Ontario, certain healthcare practitioners are required by law to report patients who may be medically unfit to drive. Under the Ontario Highway Traffic Act (s. 203 *)*, mandatory reporting requirements for high risk medical conditions, vision conditions and functional impairments that make it dangerous for a person to drive apply only to physicians, optometrists and nurse practitioners (NP). If, as part of their professional interactions, an RT becomes concerned about a patient's fitness to operate a motor vehicle they are encouraged to share their suspicions with the patient's primary care physician/nurse practitioner.

Patients with Certain Communicable Diseases

Under the authority of the *Health Protection and Promotion Act* (*HPPA)*, (O.Reg 135/18, s.25)), a

specified list of diseases must be reported to the local Public Health Unit by certain healthcare professionals. The following are examples of communicable diseases that must be reported to the local Medical Officer of Health:

- Chickenpox (Varicella)
- Measles
- Meningitis
- Novel Influenza Viruses

RTs are not one of the practitioners listed in *HPPA* who have a legal duty to report disease. However, because such reports are in the public interest, RTs are encouraged to communicate any concerns of a communicable disease to the patient's primary care physician/nurse practitioner. The complete list of reportable communicable diseases is available from each local Public Health Unit.

In addition, *HPPA* (s.38) now requires all healthcare professionals (including RTs) who provide immunizations to report Adverse Event Following Immunization Report (AEFIs) to the medical officer of health of the health unit where the immunization took place.

Disclosures Related to Risks

PHIPA permits **Health Information Custodians** (HICs) to disclose confidential personal health information to relevant authorities "if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons"[2].

Security of Personal Health Information

Unique challenges to the privacy and confidentiality of PHI can arise in a community care setting, particularly when PHI is being transported to and communicated in an unsecure location. The risk of information being lost or stolen is greater when it is being taken out of a more secure location (e.g., a home care company office) to an outpatient clinic or patient's home. In addition, sharing PHI in a less secure location runs a greater risk of disclosing sensitive information to individuals who are outside the circle of care (e.g., relatives, neighbours).

[2] PHIPA [s. 40(1)].

Information Privacy and Access Legislation

The specific legislation that applies to RTs depends, to some degree, on the practice setting and the nature of the RT services being provided. Relevant legislation to community RT practice may include the:

- *Freedom of Information and Protection of Privacy Act*
- *Personal Information Protection Act*
- *Personal Information Protection and Electronic Documents Act*

Freedom of Information and Protection of Privacy Act (FIPPA)

FIPPA applies to most provincial agencies, Ontario Health atHome and public hospitals. It gives individuals in Ontario access to government health information, including general records and records containing their own personal information. If an individual feels their privacy has been compromised by a public institution governed by the *Act*, they may lodge a complaint to the Information and Privacy Commissioner of Ontario (IPC) who may investigate the complaint.

Personal Health Information Protection Act (PHIPA)

PHIPA establishes the rules in relation to the collection, use and disclosure of PHI. These rules apply to all HICs and to individuals and organizations that receive PHI on behalf of the HIC (Agents of HICs)[3]. The *Act* defines HIC and Agents of HICs as follows:

Health Information Custodian

A HIC is the person or organization who has custody of PHI on behalf of patients, such as:

- Health Care Practitioners who operate a healthcare practice
    - Includes anyone who provides healthcare services for payment, regardless of whether or not the services are publicly funded. *PHIPA* defines "healthcare" as any assessment, care, service or procedure that is done for a health-related purpose[4].

- Community Health Facility
    - Includes diagnostic facilities (e.g., sleep studies, pulmonary function testing) and surgical/therapeutic facilities (e.g., anaesthetic services for out-of-hospital surgical procedures).

[4] *Personal Information Protection Act*. (2004).

- Service Providers who provide a community service (as defined by the *Home Care and Community Services Act)*
    - Includes long term care homes, retirement homes or home for special care

HICs are responsible for implementing and following information practices that comply with *PHIPA.*

For example…

If an RT is working independently (e.g., is a sole practitioner; has established their own company), they are considered to be the HIC. This means that the RT is responsible for setting the privacy standards for handling and securing PHI in their organization and for making sure that any agents of the HIC working for them understand what is expected of them.

Agents of Health Information Custodians (HIC)

An agent of a HIC includes anyone who is authorized by the HIC to provide services on behalf of the custodian with respect to PHI. Examples include:

- Employees of the health information custodian; and
- Volunteers or students who have any access to personal health information.

For example…

If an RT is working as an employee for an organization (e.g., home care company, FHT), they are considered to be an "agent of the HIC". This means that the RT must comply with the *PHIPA* policies put in place by the HIC (their employer).

All patient medical records must be stored securely to ensure the integrity and confidentiality of their PHI. Paper records must be stored in:

- Restricted access areas; and/or
- Locked filing cabinets.

Retention of Electronic Medical Records

Electronic Medical Records (EMR) must be backed-up on a routine basis and back-up copies stored in a physically secure environment separate from where the original data is normally stored. All PHI contained on an EMR, external storage media, or a mobile device must be strongly encrypted. Various enterprise solutions (e.g., patient portals) can provide encryption, and an increasing number of encryption applications are available for use on personal devices such as smartphones. RTs considering using unsecured or unencrypted email or text messaging should do so only for information that does not include identifiable personal health information (e.g., scheduling, reminders).

Under *PHIPA*, if a HIC is in the custody of a patient's PHI that is lost, stolen or used or disclosed without proper authority, the HIC must notify the individual at the first reasonable opportunity.[5]

Transfer of PHI

A HIC may transfer a patient's PHI records to the custodian's successor, provided the HIC makes reasonable efforts to give notice to the patient(s) before transferring the records or, if that is not reasonably possible, as soon as possible after transferring the records.

Disposal of PHI

RTs who are a HIC have a legal requirement to retain patient's PHI for the following time periods:

- Adult patients: records must be kept for 10 years from the date of the last entry in the record;

- Patients who are children: records must be kept until 10 years after the day on which the patient reached or would have reached the age of 18 years.

If an RT ceases to practise or act in the capacity of a HIC, the PHI must be retained for the periods outlined above unless complete custody and control of the records are transferred to the custodian's successor.

When the obligation to retain medical records outlined above comes to an end, the PHI may be destroyed, provided that this occurs in a manner that is in keeping with the obligation of maintaining confidentiality and requirements of *PHIPA*.

[5] *PHIPA* [s.12(2)]

Disposal of Electronic Medical Records (EMRs)

There are basically two ways to securely destroy digital information:

1. physically destroy the storage media; and
2. overwrite the information stored on the media

The best method to securely destroy personal information will vary depending on the type of media (e.g., hard drives, USB flash drives). Note that some devices, such as printers, fax machines, and smart phones, may contain multiple types of storage media, with each type requiring a different information destruction method[6].

Personal Information Protection and Electronic Documents Act (PIPEDA)

The Office of the Privacy Commissioner of Canada oversees compliance with the *Personal Information Protection and Electronic Documents Act* (PIPEDA), which is federal legislation relating to data privacy in the private sector. Therefore, PIPEDA generally only applies to RTs working in private practice.

Privacy Breaches

A privacy breach involves the improper or unauthorized collection, use, disclosure, retention or disposal of personal information. A privacy breach may occur within an institution or off-site and may be the result of inadvertent errors or malicious actions by employees, third parties, partners in information-sharing agreements or intruders.

Regardless of the nature of the breach, they must be reported by the HICs to the Information and Privacy Commissioner of Ontario. No actual harm has to have happened to the patient as a result of the breach for reporting to be required.

RTs are subject to prosecution for breaches of *PHIPA*. An RT found guilty of committing an offence under *PHIPA* can be liable for a fine of up to $50,000, while an organization/institution can be liable for a fine of up to $500,000[7].

[6] Information and Privacy Commissioner of Ontario. Disposing of Your Electronic Media

[7] Information and Privacy Commissioner of Ontario. Potential consequences of a breach under PHIPA | Information and Privacy Commissioner of Ontario

Privacy breeches can occur in a number of different ways.

- unguarded conversations;
- lost/misdirected documents (e.g., a patient's file being left on public transit, PHI being sent to the wrong patient);
- use or disclosure without authority (i.e., accessed by someone who is outside of the circle of care); or
- stolen information (e.g., paper records or laptop, being taken from the RTs car; ransomware or other malware attack on a FHT's computer system)*.

* Note that the HIC does not need to notify the Commissioner if the stolen information was de-identified or properly encrypted.

Professional Incorporation

The CRTO has processes in place to issue Certificates of Authorization for health profession corporations. RTs who independently practice Respiratory Therapy are not currently required by the CRTO to do so through a health profession corporation.

More information on Professional Incorporation can be found on the CRTO website in the section entitled Guide to an Application for a Certificate of Authorization for Health Professional Corporations.

Fees and Billing

Not all services or equipment that a patient/client in the community requires may be covered by OHIP. As a result RTs, or their employers, may have to deal with fees, billing and payment for care that is covered by the patient/client directly, or a **third party payer** such as the Assistive Devices Program (ADP) or private insurer. RTs should understand that money often changes individuals' expectations regarding services being provided as they perceive themselves to be consumers[ii]. This shift alone can alter the power imbalance between healthcare provider and patient/client, at least at the time money is changing hands. RTs have a professional obligation to ensure that their business practices are transparent, ethical and not misleading to the public[iii].

Communicating Fees and Billing to Patients

RTs are expected to clearly and accurately inform patients of all required fees for products and services, ensuring that there are no hidden costs, prior to the initiation of care[iv].

Avoiding fee conflicts…

The CRTO recommends that RTs consider implementing a checklist or consent form that patients/clients would sign, outlining fee schedules and clearly describing billing procedures including:

- any penalties for missed or cancelled appointments;
- late payment of fees;
- the facility's policy regarding the use of collection agencies to collect unpaid fees; and
- third party fee payments (e.g., private insurers).

In addition to helping to guide you, or your employees' discussions with patients/clients, if there is a dispute later you will both have a record of the information communicated. RRTs are also expected to establish processes for detailing fee or billing discrepancies and errors in a timely manner. Making these processes transparent will further reduce conflicts.

Overcharging or Excessive Fees

Charging a fee that is excessive for the services or equipment provided is a form of dishonesty. . Similarly, requiring a patient/client to purchase upgraded equipment or additional services without their prior knowledge or ability to opt out is unethical and unprofessional.

Offering Discounts

Actions that may be perceived to lessen the value of the professional, the profession or health care as a whole is not allowed. It is permissible for an RT to offer discounts for their services as longs as certain provisions are in place; discount advertisements must not state anything false or misleading, and the RT must not try to recoup the discounted fee by raising fees for other services.

Offering a reduction in cost for prompt payment is not allowed as it gives preferential treatment to those who have the financial resources to take advantage of this discount, while essentially penalizing those who don't have the means to. This does not prevent RRTs from being able to implement additional charges for late payments; the terms of late payment charges should be clearly outlined for patients/clients in advance.

Payment Options

Respiratory Therapists should explain all payment options available to their patients/clients. This includes explaining coverage through ADP and inquiring as to whether the patient/client has private insurance coverage, and the limitations of that, if known. RRTs should be cognisant of patients/clients who are financially vulnerable and communicate sensitively regarding billing.

Dealing with Third Party Payers

Many services and equipment required by patients/clients of RTs will be covered by OHIP or, at least in part, by the ADP under the Ministry of Health. The balance of fees not paid directly by

one of these two entities may be covered by private health insurance or may require payment directly from the patient/client. Respiratory Therapists may not charge a higher fee for insured patients/clients than those who pay directly. RTs should become familiar with the insurance requirements of their patients/clients in order to ensure their billing or invoicing practices will result in the claim being processed. Billing to third-party payers must reflect a true account of services/equipment provided and collected by your practice.

Professional Advertising

Professional advertising relates to any material that is used to promote an RT's professional practice.

Regardless of the advertising method, there are some common considerations when advertising RT services.

An RTs professional advertising must not:

- contain false or misleading statements (e.g., stating that your services are "CRTO endorsed");
- It must not contain statements that cannot be verified (e.g., stating that your services are "the best in the region");
- demean another member of your own profession or another profession (e.g., stating that they "…provide superior home care services when compared to all other healthcare providers");
- advertise products and services that the RT does not have the competence to provide; and
- contain a name different than the name that the RT has registered with the CRTO (i.e., the public must be able to find the RT on the public Register of Members on the CRTO website).

The *RHPA* grants regulatory Colleges the authority to develop a regulation governing advertising. RTs in Ontario must adhere to all the advertising parameters set out in the *CRTO Advertising Regulation*. In addition, the performance requirements for RTs regarding advertising and marketing are articulated in the CRTO Standards of Practice (Standard 1 – Business Practices).

Business Ethics

Solicitation of Patients

Solicitation involves contacting individuals directly to encourage them to use an RT's services and is not permitted
The *CRTO Advertising Regulation* (s. 5) states that an RT must not initiate contact with any persons for the purpose of soliciting business.

Testimonials

It is a conflict of interest to contact a patient/client for personal testimonials. The *CRTO Advertising Regulation* [s.23(2)(e)] and the CRTO Standards of Practice states that RTs must not include patient/client or patient/client family/friends testimonials in their advertising.

For example…

If a patient/client is asked for a testimonial, they may be concerned that refusing could negatively affect their relationship with the RT. This can also be true for former patients, who may feel uncomfortable in returning for treatment in the future.

Professional Practice

Regulated Health Professional Act

The *Regulated Health Professions Act* identifies a number of specific activities as controlled acts; designated as such because they carry a higher degree of risk of harm associated with their performance. These controlled acts are subsequently authorized through profession specific legislation, such as the *Respiratory Therapy Act*.

Exception in the RHPA

There are a number of exceptions in the *RHPA* [s.29 (1)] that enable individuals to perform controlled acts that they do not have the legislative authority to perform. The two exceptions that are most relevant to community practice are as follows:

- treating a member of the person's household (e.g., a patient's family member administering invasive mechanical ventilation to the patient/client in their home); and

- assisting a person with their routine activities of living (e.g., a Personal Support Worker (PSW) suctioning a patient in an outpatient tracheostomy clinic).

More information on the controlled acts authorized to RT's and the exceptions to these can be found in the CRTO's Interpretation of Authorized Acts Professional Practice Guideline.

Administering a Prescribed Substance (5th Authorized Act)

The 5th authorized act ("*administrating a prescribed substance*") enables RRTs to independently administer oxygen. "Prescribed" in this context means prescribed in regulation[8] and "independently" means the oxygen therapy can be provided without the requirement of an order.

This means that, in certain practice settings, RRTs can administer initiate, titrate or discontinue oxygen based solely on their own professional judgement. However, it is important to understand that there are other pieces of legislation and policies limiting where RTs can independently administer.

RTs are authorized by the Prescribed Procedures regulation to perform an arterial puncture. This procedure can be performed by an RT in any employment setting (e.g., hospital, an outpatient clinic, a patient's home) provided it is permitted by their employer.

The *Public Hospitals Act*[9] requires an order for every treatment or diagnostic procedure . Therefore, RRTs are only permitted to independently administer oxygen in practice setting where this legislation does not apply (e.g., in a patient's home).

Assistive Devices Program (ADP)

The Assistive Devices Program (ADP) authorizes RRTs who meet specific criteria to complete the Application for Funding Home Oxygen in place of the prescriber. Therefore, when a physician or a nurse practitioner prescribes home oxygen therapy, an eligible RRT may complete the application – provided they are not employed (full-time, part-time or casual) by a home care company. Note: GRT's are not permitted to sign ADP forms.

[8] General Regulation (O. Reg. 596/94 – PaRT VII) - Prescribed Procedures

[9] Public Hospital Act, O. Reg. 965 s. 24 Public Hospitals Act, R.S.O. 1990, c. P.40 | ontario.ca

More information can be found of the CRTO website in the section entitled ADP Home Oxygen Application - CRTO

Local Health Integration Network (LHIN) Home and Community Care Services

14 Home and Community Care Support Service agencies across the province provide access to home and community care services for Ontario residents and co-ordinate admission to long-term care facilities. These HCCSSs coordinate access to a wide range of contracted services in the community, including Respiratory Therapy in some regions.

Terms, Conditions and Limitations on an RTs Certificate of Registration

Terms, conditions and limitations (TCLs) are restrictions placed on the certificate of registration of certain classes of registration and on certain Members for specific reasons.

GRTs are only permitted to perform a controlled act that is authorized to the profession if it is performed under general supervision. This supervision can be provided by any regulated healthcare professional (e.g., RT, RN, MD) who is authorized to perform the controlled act and is competent to do so. General supervision requires that the supervising healthcare professional be available to be present by the RTs side within ten minutes, if necessary.

Providing Care in a Community Setting

Care in the community, particularly home-based care, is fundamentally different than the episodic, targeted interventions of the acute care system. Service provided near or in a patient's home requires a uniquely holistic, self-directed and person-centered approach to care delivery. Home-based care presents opportunities to better integrate the plan of care into the patient's day-to-day environment, but also presents some challenges as well, such as:

- Lack of control over elements of the home environment (e.g., location, cleanliness, available of amenities);
- Interactions with other household members (e.g., dysfunctional interpersonal relationships within families);
- Threat to the RTs safety (e.g., patients/family member engaging in illegal activities, aggressive pets); and

- Maintaining professional boundaries (e.g., avoiding conflicts of interest).

Conflict of Interest

The primary goal of healthcare is to optimize the health of patients/clients. This means that the interest of the patient/client must always come first and not financial interest. A conflict of interest arises when a secondary goal (e.g., personal gain for the healthcare provider) interferes or is perceived to interfere with the primary goal. The CRTO's Conflict of Interest Professional Practice Guideline states that "a conflict of interest exists when an RRT is in a position where his/her duty to their patient/client could be compromised, or could be perceived to be compromised, by a personal relationship or benefit". The nature of community practice (i.e., long standing RT and patient/family interactions; financial compensation for services provided) has the potential to increase the risk of a conflict-of-interest situation developing. Any actual, potential or perceived conflict of interest must be properly identified, avoided and managed so as not to compromise the patient's/client's best interests.

Identifying a Conflict of Interest

The first step is to recognize that a conflict-of-interest situation may exist. The *Conflict of Interest Regulation* (O. Reg. 596/94) outlines the situations in which an RRT might find themselves in an actual, potential or perceived conflict of interest [s. 3 (1)]. The likelihood of a conflict of interest increases when:

- The magnitude of the benefit is substantial;
- The benefit is personal;
- It involves a patient/client (or their family) where there is an ongoing professional relationship (e.g., a current home care patient/client offers their RT a piece of antique China).

Strategies to Avoid/Manage a Conflict of Interest

Disclosure and Patient Choice

In situations where a conflict-of-interest situation exists, the RT must declare the nature of the relationship/benefit to the patient/client in advance of services being provided. This should occur regardless of whether the conflict of interest is actual, potential or perceived.

For example…

An RT who works for a hospital that is part of a hospital-home care company business relationship is making arrangements for an inpatient to be discharged with home oxygen. In addition to the home care company that is associated with the hospital, the RT should – if possible - provide the patient with other appropriate service providers. Where applicable, the RT should advise the patient/client that their selection of a supplier or a product or service will not adversely affect the assessment, care or treatment that they receive. This enables the patient to exercise informed choice over the services provided to them. This includes allowing them to select a service provider, as well as the type of equipment/treatment received.

Working with Other Members of the Healthcare Team

RTs practicing in the community typically work with a diverse group of healthcare providers; some of whom are Regulated Health Care Professionals (RHCPs) (e.g., RNs, MDs, RSLPs), as well as some who are Non-Regulated Health Care Providers (NRHCPs) (e.g., PSWs, Customer Service Technicians).

NRHCPs can include an array of paid care providers and unpaid family members. One of the key considerations for RTs when working with NRHCPs in the community is to determine which services the NRHCP can provide to the patient/client and which services are best provided by the RT. Communication and collaboration with all members of the healthcare team and the patient/clients family is key to ensure that their needs are met. If the RT has any concerns regarding the care their patient/client is receiving from any member of the healthcare team, the RT is expected to raise those concerns with the patient's/client's primary care physician/nurse practitioner.

In addition to assisting other members of the healthcare, the RT practicing in the community is expected to know when it is appropriate to seek assistance from others.

More information on NRHCPs can be found on the CRTO website in the section entitled Working With Non-Regulated Health Care Providers.

Education and Delegation

Due to the fact that community-based RTs interact with such a wide variety of care providers, it is essential to understand the difference between delegation and education, as well as which is required in certain circumstances. The Delegation of Controlled Acts and the Respiratory Therapists Providing Education provides detailed information on these two processes

Electronic Communication

Despite the convenience of many communication mediums, the use of electronic communications to transmit sensitive information can increase the risk of such information being disclosed to third parties. The eCommunication Checklist produced by the Canadian Medical Protective Association provides some essential elements to considered when using electronic communication to convey sensitive PHI.

eCommunication checklist[10]

- Is communication within the circle of care?
- Is explicit (written) consent of the patient required?
- Is the information secure (encrypted)?
- Is your device password protected?
- What are the relevant regulatory standards?
- Is only essential information being shared?
- Is person-to-person communication more appropriate?

Obtaining Patient Consent to Communicate Electronically

Prior to engaging in electronic communication mediums patients should agree to:

- The method of communication;
- The type of information that will be sent;
- How the information contained in the communication will be retained/deleted; and
- The risks of using electronic methods of communication.

[10] Canadian Medical Protective Association. Retrieved from https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/communication/Privacy_and_Confidentiality/ecommunication-e.html

The discussion and patient's agreement should be documented in the medical record. In addition, the Information and Privacy Commissioner of Ontario has published a Fact Sheet on Communicating Personal Health Information by Email that addresses the risk of email communication and how those risks might be mitigated.

Professional Boundaries

In keeping with the Standards of Practice, "Respiratory Therapists must act with honesty, integrity, and respect appropriate **professional boundaries** with **patients/clients**, **healthcare team** members, students, and others." While most RTs will reflect on "professional boundaries" in relatively limited terms, such as romantic or financial relationships, professional boundaries covers every aspect of communication and interaction between RTs and everyone with whom they come into contact in their roles.

More information can be found regarding Professional Boundaries in the CRTO Respiratory Therapists Providing Education PPG and the Abuse Awareness and Prevention PPG.

Medical Assistance in Dying (MAID)

In 2016, the federal government passed legislation to amend Canada's Criminal Code and established a framework for Medical Assistance in Dying (MAID) for individuals who meet pre-defined eligibility criteria. RTs in community practice may be required to provide information to patients seeking information about MAID or to assist a physician or NP in carrying out a request for a medically assisted death. Therefore, it is important that a community-based RT be knowledgeable about the following:

- How to handle inquiries about MAID (i.e., criteria for MAID, who the RT can discuss MAID with); and
- RT's role in MAID (i.e., parameters around assisting MAID, acting as an independent witness, conscientious objection).

The above information, as well as addition resources can be found on the CRTO website in the section on the Medical Assistance in Dying.

Ending Professional Relationships

In most circumstances, RTs in community practice are obligated to maintain a professional relationship with a patient as long as the patient requires services from the RT. However, situations may arise that require the RT to end the professional relationship prior to reaching the normal or expected conclusion of the patient's treatment. These situations generally fall into one of two categories where the RRT will no longer able to provide the services:

1. Logistical Reasons (e.g., the RT is retiring or leaving to work for another organization); and/or

2. Safety and/or Interpersonal Concerns (e.g., RTs feel the patient's home environment poses a threat to the safety of the RT or others; there exists a significant conflict with the patient and/or their family members).

Ending Professional Relationships due to Logistical Reasons

In this situation, care must be transferred to the most appropriate service provider prior to the RT ending the professional relationship. Most organizations have polices in place to deal with the transfer of care process. The section entitled "Transfer of Care" below deals with some recommendation from the CRTO.

Ending Professional Relationships due to Safety and/or Interpersonal Concerns

Except where there is a genuine risk of harm, RTs should only end the professional relationship after reasonable efforts have been made to resolve the situation in the best interest of the patient. These efforts must include:

- Proactively communicating expectations for patient conduct to all patients; and
- Having a discussion with the patient regarding the reasons affecting the RT's ability to continue providing care.

All reasonable efforts must be made to resolve the situation in the best interest of the patient, and only consider ending the professional relationship where those efforts have been unsuccessful.

For example…

Most home care companies have a policy in place to deal with situations where there is unsafe use of oxygen in the home (e.g., oxygen in use while patient/family member is smoking). These processes generally include all of the following steps:

1. Inform the patient (preferably in writing) of what will happen if they use oxygen in an unsafe manner (i.e., how many warning they will receive and how those warning will be documented);
2. Notify the patient (preferably in writing) of the decision to discontinue their treatment;
3. Document in the patient's medical record the reasons for the discontinuation of services, as well as all steps undertaken to resolve the issues prior to discontinuation;
4. Clearly convey to the patient that they should seek ongoing care (e.g., speak to their primary care physician; go to their local emergency department); and
5. Notify the healthcare provider(s) who ordered the oxygen that the therapy is no longer being provided to the patient. Also consider informing the funder of oxygen services (i.e. MOH Home Oxygen Program) and other members of the patient's healthcare team, as appropriate.

Transfer of Care

When transferring full or partial responsibility for a patient's care to another healthcare provider, an RT is expected to communicate with the:

- patient to identify the roles and responsibilities of the regulated member and other healthcare providers involved in the patient's ongoing care; and
- accepting healthcare provider(s) to provide any pertinent clinical information, including treatment plans and recommendations for follow-up care.

Transfer of Patient Files

It is important to obtain appropriate authorization (i.e., consent) from the patient before transferring any copies of medical records. The RT should ensure the original records are retained in the event there is some question at a later time about the care you provided to the patient, or in the event of a complaint to the CRTO or legal action surrounding the care or the termination. In addition, the RT should advise the patient of the need to transfer copies of medical records to the new physician. You should also request the necessary consent to make the transfer. Consider any Privacy Commission or CRTO guidelines that might apply to the transfer of patient records.

Documentation

The CRTO Documentation PPG and the CRTO Standards of Practice (Standard 7) outlines the principles and standards of documentation that must be maintained by all RTs in every practice setting. Documentation styles and documentation mediums vary from one organization to the next. RTs may utilize any documentation format that meets both the CRTO's expectation regarding documentation and their employer's requirements.

An essential foundational principle for all RT documentation is that every patient contact must be documented. "Patient contact" includes (but is not limited to):

- performing an examination, diagnostic procedure, therapeutic intervention;
- providing education to a patient and/or their family, caregiver or advocate; and
- conferring with other members of the healthcare team (including the patient's family members) regarding the patient's plan of care (note that this includes even when the patient is not present during the conversation).

Professional Liability Insurance (PLI)

The *Regulated Health Professions Act*[11] requires all practicing regulated health professionals to carry PLI that meets specific criteria. The CRTO Professional Liability Insurance Policy outlines those requirements, as well as the consequences of an RT not being covered by the requisite amount of PLI.

RTs who are "personally insured" by their employer's PLI plan in the required amounts and coverage are not obliged to obtain additional liability insurance coverage. "Personally insured" means the employer's insurance policy covers not just the organization, but the RRT as an individual. The policy does not have to list the RT by name but must specify that it covers the "employees" of the organization as "added insureds".

Additional PLI is available for members of the provincial or national professional associations (i.e., the RTSO, CSRT).

Reporting Requirements

There are a number of instances where an RT is required to report specific information to certain organizations/agencies. Some of these reporting requirements were covered in the section in this document entitled **Sharing PHI Outside of the Circle of Care.** More information on other reporting requirements can be found in the CRTO's Reporting Obligations webpage. When an RT has reasonable grounds, obtained in the course of practicing the profession, to believe that another RT or regulated health professional has sexually abused a patient, the RT must file a report in writing with the Registrar of the College to which the alleged abuser belongs.

More information on the reporting of sexual abuse of patients can be found in the CRTO Abuse Awareness and Prevention PPG.

Reporting to Other Agencies

Depending upon the community practice setting, there may be other mandatory reporting requirement to agencies outside of the CRTO that are governed by different legislation (e.g., *Long-Term Care Homes Act*). Listed below are just a few addition reporting obligations.

[11] RHPA. Health Professions Procedural Code. S. 13(1).

Considerations When Establishing an Independent RT Community Practice

Although the majority of RTs who work in the community are employed by home care companies or community care clinics, RTs are able to set up their own independent practice. This requires the RT to establish processes for securing patient's health records, set fees for their services, ensure they have the required level of professional liability insurance and that they attain optimal business ethics.

The CRTO recommends any RT who is establishing an independent community practice to consult their own legal advisor.

http://practicemanagement.dentalproductsrepoRT.com/aRTicle/how-changing-patient-expectations-will-impact-your-practice?page=0,1 (July, 2018)

[iii] CRRTO Standards of Practice, Standard 1 – Business Practices

[iv] Ibid.