



# Respiratory Therapy Society of Ontario

## Société de la thérapie respiratoire de l'Ontario

March 15, 2006

Jennifer A. Crawford  
Assistant Counsel  
SARS Commission  
180 Dundas St. W, 22<sup>nd</sup> Floor  
Toronto, ON M5G 1Z8

Dear Ms Crawford:

**Re: Respiratory Therapy Society of Ontario (RTSO) submission to SARS Commission final report**

On behalf of the RTSO I write to thank you for the opportunity you have afforded us to respond as the professional association representing Respiratory Therapists in Ontario. Respiratory Therapists are a body of health care providers who were intimately involved in the clinical care of patients with respiratory distress in emergency departments, critical care and general care units, as a direct result of the SARS virus infection. A number of our colleagues were infected with the virus and were admitted and treated in acute care facilities. There were also members of our profession who were quarantined as a result of exposure to patients in the community and acute care. The SARS experience has left us with lasting impressions.

We acknowledge that prior to the SARS crisis there were infection control standards regarding personal protective equipment (PPE) for individuals involved in the performance of respiratory droplet generating high risk procedures. During the SARS outbreak these standards were restated including isolation directives and PPE "plus" (PAPR & Stryker suits). PPE "plus" was added presumably because of the unknown nature of the pathogen's spread.

Preceding the SARS outbreak there was an observed general complacency related to the use of personal protective equipment (PPE) as an infection control practice when performing respiratory droplet generating high risk procedures. Post SARS there appears once again to be, perhaps more predominantly in the institutions/employees who were not directly impacted by SARS, a similar re-emerging complacency regarding the use of PPE.

In addition we believe that some of the confusion and fear during the SARS outbreak was the result of:

- a lack of awareness/understanding of infection control standards
- confusion related to the SARS virus and its' mode of transmission, resulting in mistrust when the MoHLTC directives were disseminated as to their practicality and relevance due to:
  - o initial lack of direct input
  - o the need for constant and frequent revision
- messages (through media and word of mouth) that health care workers were becoming sick despite following ministry infection control directives resulted in greater fear, distrust and confusion regarding how to protect ourselves and what we were dealing with
- a lack of Respiratory Therapist input into protection procedures in the initial stages of the outbreak, subsequently a number of the recommendations were impractical to implement. This resulted in a mistrust of the recommendations and the planning process.

- a lack of appreciation and understanding by the MoHLTC regarding the multi-disciplinary nature of the care team, therefore not all of the key health care team members, Respiratory Therapists specifically, were participants in the initial decisions and development of the provincial directives at the outset of SARS.

A focus group of Respiratory Therapists, consisting of clinical leaders and practitioners formulated the following observations and recommendations in consideration of the SARS Commission's request for submissions to the final report.

Four primary themes were identified for consideration:

1. Communication
2. Standards and Enforcement
3. Education
4. Planning

## **1. Communication**

### **Proposals/Recommendations**

- implement and follow a communication strategy model and structure (e.g. Plan-Do-Study-Act)
- multi-disciplinary involvement from experts is invaluable (good models exist such as at UHN with the Allied Health approach)
- value professional society involvement
  - o this requires funding
  - o acknowledge and correct the present disparity of support by the MoHLTC to assist financially, provincial associations to develop clinical practice guidelines/professional practice standards. Some provincial regulated health care professional associations receive annual funding from the MoHLTC. These funds are specifically earmarked for practice guideline development. Many of the guidelines and standards will impact more than one discipline. However, the inequity in the dispersion of current funding practice does not acknowledge the multi-disciplinary nature of the health care team and risks losing the richness of the varied perspectives of different disciplines
- communication links with educational institutions to include students
- supported on-going professional development
- communication links within the RT community to foster collaboration, cooperation and development of best practices

### **Unanswered Questions**

- communicating the result of the disproportionate attention/resources applied to the impact on travel and tourism vs healthcare?
- preparedness, how do we get healthcare back to pre-SARS levels of confidence?
- communicating the importance of having surge capacity (for both staff and facilities)?

## **2. Standards and Enforcement**

### **Proposals/Recommendations**

- accountability for adherence to standards
- interdisciplinary input into guidelines
- standards must be evidence-based
- ensure coordinated and consistent messaging
- a comprehensive communication strategy for dissemination of new or altered guidelines (posting on the MoHLTC website in itself is not enough)
- resources and support to implement

- empower front-line staff to participate in planning and compliance
- action plan for how information will get to the front-line staff
- institutional level accountability for education related to current infection control guidelines, standards and directives
- make practices and signage regarding PPE standards universal and consistent across the health care system

### **Unanswered Questions**

- will the documents be classified as directives or guidelines?
- who will create/revise standards of practice?
- who will be accountable for enforcement?
- what will the consequences be for non-compliance?

### **3. Education**

#### **Proposals/Recommendations**

- education and training regarding mask fit-testing for use of an N-95 mask; e.g. when it is required when it is not.
- awareness and enforcement of mask fit testing for N-95 mask use was raised as a priority for the first time during the SARS outbreak. Yet mask fit testing has been a standard in the National Institute for Occupational Safety and Health (NIOSH) recommendations regarding N-95 mask use. N-95 masks were in use pre SARS in health care to protect practitioners when treating patients with airborne transmitted pathogens; e.g. tuberculosis; yet mask fit testing was not universally applied pre SARS.
- improve understanding and awareness of existing and new guidelines
- need profession specific involvement with infection control teams with respect to education and awareness
- empower Infection Control Practitioners with the authority to enforce current standards, guidelines and basic infection control practices
- increase curriculum content regarding infection control practices for student programs
- continue to develop and improve educational programs for all Health Care Professionals regarding infection control

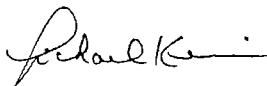
### **4. Planning**

- the general messages were focused on ensuring a role for Respiratory Therapists to continue to provide their expertise at local and provincial levels for infection control and pandemic planning
- a common belief that a multi-disciplinary approach is essential and invaluable
- planning is primarily a non-crisis scenario activity and should be used to help build confidence in Ontario's preparedness for the next event

I look forward to the final report of the SARS Commission and thank you once again for the opportunity to participate.

Sincerely,

RESPIRATORY THERAPY SOCIETY OF ONTARIO



Michael Keim, RRT  
Past President