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PART II

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contents

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Thank You

Many of us have faced the challenges of the worldwide economic crisis. There isn't a person or family that hasn't been impacted in some way. As a result, some people have chosen to delay their retirement, many have returned to some form of paid employment to supplement what the slumping stock markets have done to pensions, some have curtailed trips and many reduced discretionary spending. However, one of the positive impacts of the slumping economy is the fact that many people have turned toward some type of volunteer work to make a positive difference in the lives of others and to "give back" to their churches, community, and professions.

As a profession, we have benefitted from the decision of many members who have offered to become involved with the College. As a result of a "call for volunteers," the Registrar received numerous applications from people, all with a desire to contribute their time and expertise to support the work of the College as "non-Council" committee members. People have responded that they want to be able to share their experiences to shape the College of the future, support the activities and decisions of the College and mentor those just starting in the profession. Many people are at a "place" in their personal and professional lives where they can take the time to "give back" to the professions. We will all benefit from their experience and expertise. I also believe that people are looking at how their lives have defined them and realizing that what they give to others routinely, defines who they are. If we make a habit of "volunteering" to support others, the "volunteer spirit" ultimately defines part of who we are.

The decisions regarding those applications will be made in June when the choices regarding committee composition are made for the entire Council. Those people who will come on to a committee will be notified as to the schedule of the meetings commencing in the fall. Thanks very much to all whom have submitted a letter of interest. Your response has been truly exciting and very generous. Congratulations on your desire to "give" in such a meaningful way to the professions.

I would also like to extend my "thank you" and "best wishes" to Lynne Latulippe, the Manager of Professional Conduct for many years, who has taken a new position at another College. I have had the pleasure of working with Lynne on many committees and want to thank her for her dedication, responsiveness, concentration to detail and efficiency. I mostly want to thank her for being the ultimate professional "with a soft touch" that she was. Lynne provided support and guidance in a kind and caring way and went the "extra mile" for people. Lynne will be missed.

Meg Petkoff,
President CASLPO

March 2009 Council Highlights

Council held its regular meeting on March 6, 2009. The following are the highlights.

- Council approved the Position Statement on Completing ADP Forms in principle for discussion with stakeholders. Meetings will be requested with the Association of Hearing Instrument Practitioners, The Ministry of Health and Long-Term Care Assistive Devices Program, and OSLA.
- Council discussed whether or not to approve a change in position on mandatory Real-Ear Coupler Difference (RECD) measurements to make them optional in the Hearing Assessment of Adults and Dispensing PSGs. Council approved the recommendation from the Audiology Committee that RECDs be made optional and this statement be included in the PSG on Dispensing; and that it be distributed to all members as an addendum to the PSG on Hearing Assessments for Adults.
- Council discussed the SLP Practice Advisory Committee's recommendation to proceed with the completion and publication of the PSG on the Process for the Assessment of Adults by SLPs, based on the Child Assessment PSG. It was agreed that Council would consider the SLP Practice Advisory Committee's recommendation at the June Council meeting when priorities for 2009/2010 are considered
- Council discussed whether or not to approve the Audiology Practice Advisory Committee's recommendation that the College's position on inter-octave thresholds be modified in the PSG on Hearing Assessment of Adults. Council agreed that the PSG standard be modified to require testing of inter-octave thresholds when the difference between the thresholds at adjacent octaves is greater or equal to 20 dB (per the ANSI standard) and that audiologists should measure thresholds at 3 and 6 KHz because of their importance to speech intelligibility.
- Council discussed matters related to the formation of the Inquiries, Complaints, and Reports Committee (ICRC). Council approved that the composition of the Inquiries, Complaints, and Reports Committee (ICRC) would be eight including the Vice Presidents of Audiology and Speech-Language Pathology. It was agreed that Council would discuss at the June meeting, guidelines related to the various dispositions that are available to the ICRC with respect to complaints and reports. A summary of past decisions of the complaints and executive committees will be reviewed.
- Council discussed the updating and consolidation of bylaws and governance policies. Currently there are provisions in the Governance Policies that should be in the bylaws, as well as provisions that are in both the policies and the bylaws that are in conflict and should only be in the bylaws. Matters for which the College is empowered to make bylaws as outlined in the RHPA should be dealt with by bylaw. Bylaws have more weight than policies and are more readily enforceable. Most of the changes are the result of consolidating long standing requirements from existing bylaws dealing with fees, elections, appointments to committees etc., into the new consolidated bylaw. In addition those matters in the Governance Policies for which the RHPA expressly gives the College power to make bylaws have been deleted from the Governance Policies and have been placed in the consolidated bylaw. Council approved the consolidated bylaws in principle for circulation to the members for comment as required by the RHPA. Final Council approval will occur at the June meeting.

For more information on any of these topics please contact David Hodgson, Registrar at 416 975 5347 ext 215 or by email at dhodgson@caslpo.com.

Technology and Documentation

By Carol Bock and Karen Luker, Deputy Registrars

As part of our new electronic charting system, we are unable to provide a handwritten signature. We have therefore recommended that clinicians type their name and professional designation at the end of each e-chart entry. Is this sufficient to meet College standards?

Most electronic charting systems are designed to track all entries through the use of unique identifiers or passwords. This means that every entry is "coded" to identify its author. If your system is set up this way, typing your name and professional designation is sufficient to identify the entry as yours. Some systems do not provide enough room to enter full designations, such as "M.H.Sc., Reg. CASLPO." In this case, some institutions have written a short policy or statement indicating that the electronic signature in its abbreviated form actually refers to the full designation.

Supervisors have always been required to co-sign any documentation completed by their students. Our electronic documentation system does not allow for two electronic signatures on one entry. Our current practice with electronic documentation is for supervisors to write a separate electronic note indicating that they have read and agreed with what the student documented. Is this sufficient to meet College standards?

Yes, this is sufficient. One issue to be aware of, however, is the modification of chart entries. Ideally, your system should allow corrections or changes to be tracked and attributed to the appropriate author.

I am part of a multidisciplinary team of professionals who are at different locations and who work for different agencies. The parents of my client have asked me to disseminate my assessment report and regular progress notes to all team members by email. I am concerned about sending confidential information this way.

You can certainly raise these concerns with the parents, emphasizing the risks inherent in sending *any* information electronically. If they still request or insist that you provide the information in this format, you can build in a few provisions to make the dissemination more secure. For instance, you could anonymize reports and notes by replacing the client's name with a fictitious name or non-word. You could also save documents with a password, which you will share with team members under separate cover or via telephone

Use of the Title "Doctor"

By Lynne Latulippe, Manager of Professional Conduct

Members may recall that CASLPO has repeatedly advocated that members of a regulatory College who hold a doctorate degree in the discipline in which the person is registered should be allowed to use the title "doctor" in the course of providing or offering to provide health care to individuals. This is a long-standing issue for CASLPO and has been addressed in a number of submissions from the College to various government bodies since 1999. Notwithstanding CASLPO's position, the restrictions on the use of the term "doctor" remain, unaltered, in the *Regulated Health Professions Act* (RHPA).

The most recent issue of *CASLPO Today*, from February 2009, summarized the decisions arrived at by the Complaints Committee in two complaints pertaining to the use of the title "Doctor" by audiologists.

The College has also received additional complaints concerning this matter, and the investigation and decisions in two further complaints are described below.

In the first complaint, it was alleged that the member audiologist had incorrectly used the title "Doctor" on a business card, by inserting the abbreviation "Dr." before the member's name. The member responded with an apology and stated that, once the member had obtained a doctorate, the business card was printed at the direction of office staff. The member indicated that upon learning of the error, the member arranged to have the remaining cards destroyed. The member also provided documentation from office staff confirming these events and forwarded copies of other documents, including advertising and audiograms with no reference to the title "Dr." or, where the reference is included, as "Doctor of Audiology".

Upon being apprised of the member's response, the complainant accepted the member's explanation and apology.

In reviewing this information, the panel of the Complaints Committee noted the restrictions placed in the *Regulated Health Professions Act* (*RHPA*) on the use of the title "Doctor." The panel also noted the College's Position Statement on the Use of the Title "Doctor" which states that, in the course of providing or offering to provide health care, members may describe themselves as "John Smith, Doctor of Audiology" however they are prohibited from referring to themselves as "Dr. John Smith".

The panel recognized the member's apology and explanation for the improper use of the title "Doctor." The panel also noted that section 34 of the College's Professional Misconduct Regulation states that it is an act of professional misconduct to improperly advertise or permit advertising with respect to a member's practice. Thus, the panel reminded the member of the member's responsibility for the actions of staff, and noted that the member should ensure that, in the future, documentation and advertising set up on the member's behalf by staff are in compliance with College requirements.

In the second complaint, it was alleged that the member's use of the title "Dr." followed by the member's name on the Internet was prohibited by the RHPA.

The member responded that he was aware of the prohibitions pertaining to the title "Doctor" in the RHPA, and of the College's position statement on the topic. The member acknowledged the use of the title as described by the complainant but stated that the use of the title "Doctor" on a facility's website was not meant to be in the context of providing, or offering to provide, health care to individuals. The member confirmed that he is indeed affiliated with the audiology facility subject of the website, but stated that at the facility, other audiologists than he provide services. The member also stated that he is involved in a research program in the facility and that his use of the title "Doctor" preceding his name is appropriate for his role in research.

The complainant was provided with the member's response, but did not forward a reply.

The panel noted the restrictions placed in the RHPA on the use of the title "Doctor." The panel also noted that the College's Position Statement on the Use of the Title "Doctor" states that, in the course of providing or offering to provide health care, members may describe themselves as "John Smith, Doctor of Audiology"; however, they are prohibited from referring to themselves as "Dr. Smith." The panel also noted that the position statement indicates that restrictions on the use of the title "Doctor" apply only in the course of providing or offering to provide health care, and that members with doctoral degrees may indeed use the title "Doctor Smith" in academic, research and other settings.

The panel of the Complaints Committee carefully considered the member's statements regarding his role at the facility in question and his use of the title "Doctor." The panel was of the opinion that the member's use of "Dr." preceding his name occurred within the context of providing and offering to provide health care to individuals. For example, the website information is easily available to the public and to individuals, and the facility does indeed offer and provide health care (audiology) services.

The panel thus concluded that the member's use of the title "Doctor" on the Internet does not comply with the RHPA nor with the College's position statement on the use of the title "Doctor." The panel therefore advised the member to modify the website information in question to comply with the RHPA and College requirements.

CASLPO Requests a Review of Scopes of Practice:

CASLPO has proposed that the Minister of Health and Long Term Care request the Health Professions Regulatory Advisory Council (HPRAC) to review the scopes of practice of audiologists and speech-language pathologists to determine what barriers restrict them from practicing to the maximum of their scopes and to shed light on what new roles might be appropriate within a profession and how best practices can be promoted.

In the New Directions Report HPRAC stated "it would be useful to examine whether professionals are in fact practicing to the maximum scope of their practice and, if not, what barriers restrict them from doing so. Another aspect of this review would be to shed light on what new roles might be appropriate within a profession and how best practices can be promoted."

A review and change to the scopes of practice of audiologists and speech-language pathologists may:

- Improve patient care and facilitate better results for patients;
- Regulate these professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest;
- Optimize their skills and competencies to enhance access to high quality and safe services;
- Ensure access to high quality and safe services, and
- Ensure that these regulated health professionals work to their maximum competence and capability.

In its request to the minister, CASLPO cited two examples where a change to the scope of practice of audiologists and speech-language pathologists would make enhance their ability to serve their patient/clients.

Communicating a Diagnosis

For many years, CASLPO has sought to rectify one of the most problematic and confusing aspects of the RHPA which is the exclusion of audiologists and speech-language pathologists from the controlled act of communicating a diagnosis. While there is no prohibition against audiologists or speech-language pathologists from making profession-specific diagnoses based on comprehensive evaluations of communicative function, current legislation precludes them from *"communicating to a the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause or symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her representative will rely on the diagnosis."* Not only is this restriction incompatible with the roles and responsibilities that audiologists and speech-language pathologists are charged with in assessing, indentifying, preventing, and treating auditory-vestibular and speech-language disorders, but it creates unreasonable barriers to accurately communicating assessment results and recommending interventions.

It stands to reason, for example, that an audiologist who performs a comprehensive audiologic assessment on an individual and determines, based on history and findings, that communication difficulties are attributable to sensorineural hearing loss secondary to noise exposure, is obligated to communicate a profession-specific diagnosis prior to implementing an aural rehabilitation and hearing conservation plan. Similarly, a speech-language pathologist who assesses a patient that presents with a fluency disorder, such as stuttering, must be able to communicate a diagnosis in order to recommend and initiate treatment. Profession-specific diagnoses are not new, and are recognized in other Canadian provinces including British Columbia and Alberta where "communicating a diagnosis" is explicitly included within the scopes of practice for audiologists and speech-language pathologists.

Not allowing audiologists and speech-language pathologists to communicate a communication disorder diagnosis is in direct opposition to the Government's HealthForce Strategy to enable health professionals to practice to the utmost of their ability. Audiologists and speech-language pathologists should be allowed and encouraged to maximally utilize their high level of clinical expertise to the benefit of Ontarians and legislation, such as that which is already in place in British Columbia and Alberta, should be similarly adopted in this province.

Referrals to Other Professionals

Ensuring sustainability of essential publicly funded health services requires effective management of professional resources. This is especially true with respect to medical specialists, who are typically in high demand and limited supply. Consequently, access to these professionals is normally controlled by general physicians, who serve as gate keepers by issuing referrals when appropriate. For the most part, this model is effective in striking a balance between important, but competing interests of accessibility and cost-containment. However audiologists, who are uniquely positioned to identify patients that require evaluation by otolaryngologists, are not permitted to make direct referrals. As a result, audiologists are compelled to "request" or "recommend" referrals from general practitioners; this is problematic and leads to service delays, increased demands on physician resources, and additional system costs.

While the vast majority (80–90%) of hearing loss cases does not require and are not amenable to medical intervention, it is not uncommon for audiologists, as primary health care professionals, to evaluate patients who require consultation with an otolaryngologist. For example, patients who present with new onset or unexplained asymmetric, sudden or unilateral sensorineural loss or conductive hearing loss that is secondary to traumatic tympanic membrane perforation, ossicular fixation or discontinuity, chronic eustachian tube dysfunction, or deeply rooted foreign bodies, are excellent candidates for referral. General practitioners do not typically manage these conditions. Without entitlement to initiate direct referrals to otolaryngologists, audiologists have no means to determine whether "recommendations" for referral are accepted, and more importantly, do not receive specialists' reports that are traditionally sent only to the referring professional. It does not stand to reason that audiologists do not receive results from medical evaluations that were initiated by their own clinical investigations and, by extension, are denied pertinent information that may guide audiologic treatment. Ultimately, such barriers to interprofessional collaboration are against the interests of patients.

Just as optometrists are permitted to make direct referrals to ophthalmologists, so too should audiologists be permitted to make direct referrals to otolaryngologists. This would simultaneously improve accessibility, shorten wait times, alleviate burdens on general practitioners, reduce overall costs, and promote improved communication and cooperation amongst health care professionals.

Similarly, speech-language pathologists could assess a patient's speech, language, and communication disorders and determine if a medical problem was present. If a medical problem did present the SLP should be able to refer to a specialist within specific protocols. In fact, speech-language pathologists frequently are the first health care professional to encounter patients with serious underlying medical problems, including neurological conditions, oral, pharyngeal, and laryngeal pathologies, childhood developmental disorders because these medical conditions often present as a communication disorder or swallowing disorder. Currently the speech-language pathologist must refer first to the physician who then sees the patient and then refers on to the specialist.

There are other areas where audiologists and speech-language pathologists could do more if their scope of practice was expanded. Members will be kept informed of the progress of this request to the minister.

Canadian Alliance of Regulators Report

Working Together for the Professions and the Public

For a number of years the regulatory bodies in the six regulated provinces met informally to discuss matters of mutual interest relating to the regulation of the professions. In 2006 the Canadian Alliance of Regulators was formed to provide a forum for regulatory bodies to share information on regulatory matters and undertake collaborative projects to develop and harmonize standards and eliminate duplication of effort where possible.

The Canadian Alliance of Regulators of Audiology and Speech-Language Pathology (CAR) is composed of the following regulatory bodies that have been established and mandated by their provincial governments by legislation to regulate the professions of audiology and speech-language pathology and govern their members in their respective provinces:

- Alberta College of Speech-Language Pathologists and Audiologists
- College of Audiologists and Speech-Language Pathologists of Ontario
- Manitoba Speech and Hearing Association
- New Brunswick Association of Speech-Language Pathologists and Audiologists
- Ordre des Orthophonistes et Audiologistes du Québec
- Saskatchewan Association of Speech-Language Pathologists and Audiologists

The new College of Speech and Hearing Professionals of British Columbia will join CAR in the near future.

In addition to the regulators meeting from time to time, meetings of the regulatory bodies and associations were held to provide updates on activities and again discuss matters of mutual interest. Discussions suggested a need to clarify roles and mandates particularly between regulatory bodies and associations. There was also discussion on how to eliminate duplication of effort through collaboration of the associations, universities, and regulators on projects.

As a result of these discussions, The Canadian Interorganizational Steering Group for Audiology and Speech-Language Pathology (CISG) was formed. It is comprised of the Canadian Alliance of Regulators of Speech-Language Pathologists and Audiologists, The Canadian Association of Speech-Language Pathologists and Audiologists, and the Canadian Academy of Audiologists representing the professional associations and the Canadian Council of University Programs in Communication Sciences and Disorders. The CISG facilitates the sharing of information and building of consensus on matters affecting the professions. Its mandate is to coordinate the work of regulatory bodies, professional associations and universities on projects/activities of mutual benefit and interest for the betterment of the professions of speech-language pathology and audiology and to collaborate on the development of practice standards and guidelines.

The members have agreed to work together:

1. To create practice standards and guidelines that can be adopted to the greatest extent possible by all.
2. To coordinate the work of the regulatory bodies, associations and universities on matters of mutual interest to the greatest extent possible.

A project to develop Infection Control Guidelines with specific relevance to the practice of audiology and speech-language pathology in Canada is the first project of the Interorganizational Group for Speech-Language Pathology and Audiology. The intended outcomes of the project will be two documents, called the Infection Control Guidelines for Audiologists and the Infection Control Guidelines for Speech-Language Pathologists.

The Guidelines are to be completed by August 2009. Once they have been completed, the CISG will assess the process to determine whether or not a similar collaborative effort can be used in the future.

The development of the Guidelines is a great opportunity for the regulators, associations and the universities to work together for the benefit of the professions and the public. We look forward to a successful outcome.

Significant Changes are Coming to the *Regulated Health Professions Act*

Part 1 of 3: Mandatory Reports

The *Regulated Health Professions Act*, 1991 (RHPA), which is the legislation that governs Ontario's health regulatory Colleges is about to change significantly. These changes, which come into effect on June 4, 2009, will impact almost every area of the College's operations. Although many of these changes relate to College processes, a significant number of the revisions will have a direct impact on members. The purpose of this series of articles is to highlight some of the biggest areas of change and to explain the specific impact those revisions will have on members.

The majority of the legislative changes touch upon one of the following three subject areas: (i) mandatory reports; (ii) the register; and (iii) the Inquiries, Complaints, and Reports Committee (ICRC). A separate article will deal with each topic.

Mandatory Reports – Current Requirements

Members must report certain information to the College. Under the current RHPA, members and facility operators are required to advise the Registrar of the appropriate College when they have reasonable grounds to believe that a member has sexually abused a patient. For example, if a patient reports to a member during the course of an assessment or treatment that their former practitioner touched them sexually or "made a pass" at the patient, the member must report this information to the Registrar of the College of the other practitioner. The report must be in writing and contain the pertinent details. However, the name of the patient cannot be revealed unless the patient agrees in writing to this disclosure

Similarly, employers, partners, or associates are required to advise the appropriate College Registrar when they terminate the employment or association with a health professional for reasons of professional misconduct, incompetence or incapacity. For example, if a member terminates the partnership with a colleague because the colleague has stolen something from a patient, the member must report the colleague's behaviour to his or her partner's Registrar. Again the report must be in writing. In this case, so long as the conduct did not involve sexual abuse, the reporting member can, and probably should, include the name of the affected patient in the report even without the patient's consent.

Mandatory Reports – New Requirements

The existing mandatory reporting requirements will remain in place. However, as of June 4, 2009, the reporting obligations for members and facility operators are significantly expanded.

Members

Members of all health regulatory Colleges will be required to advise their own College, in writing, if they have been found guilty of an offence. An offence is a finding by a court (administrative tribunal findings do not count) of a breach of something labelled as an offence in a statute. Typically an offence is punishable by a fine or jail; however, the report must be made even if the court imposes a conditional or an absolute discharge. The best known offences are breaches of the *Criminal Code of Canada* or of federal drug legislation. However, there are a number of provincial offences as well (e.g., failing to report a child in need of protection contrary to the *Child and Family Services Act*).

The intent of this self-reporting requirement is that all offences will be reported to the College and then that College will sort out which offences are worthy of further inquiry. If the finding raises no apparent concerns (e.g., a traffic offence that does not involve dishonesty or impairment), the College will simply file the report. If the finding raises concerns relevant to the member's suitability to practise the profession (e.g., a criminal conviction for fraud), the College will investigate the matter to determine if some regulatory action should be taken (e.g., remediation, discipline). Thus, members should not "self-select" which offences they believe are relevant or worthy of a report; that determination is supposed to be made by the College.

In addition, members will also be

required to file a report with their own College if there has been a finding of professional negligence or malpractice made against them by a court. These findings occur in civil proceedings or law suits. For example, a finding of professional negligence by a court that a member fell below the accepted standard of practice of the profession and thereby harmed a patient has to be reported. The College may inquire into these findings where appropriate. However, unlike offences, in all cases the College must post the court finding in the public register.

These new provisions are a self-reporting obligation only. Other practitioners do not have to make a report if they become aware of a finding made against someone else (although in some circumstances a member may conclude that he or she has an ethical obligation to notify the College of a serious court finding).

These obligations are not retroactive. Thus, there will be no duty to report findings made by a court before June 4, 2009.

Facility Operators

In addition to the existing requirement to report sexual abuse, facility operators will now also be required to report to the appropriate College Registrar any reasonable grounds to believe that a member practising at the facility is incompetent or incapacitated. This new reporting obligation is in addition to the existing "termination" reports. Thus if the registered health practitioner is not fired or otherwise terminated, but is just put on restrictions or sent for treatment or remediation, a mandatory report must still be made.

The RHPA does not define the word "facility." However, given the public interest purpose behind this amendment, it likely is intended to capture any physical premises where registered health care practitioners practice.

In order for facility operators to fully understand and appreciate the obligation that this new reporting requirement creates, however, they will need to have a clear understanding of how "incompetence" and "incapacity" are defined by the RHPA. Incompetence refers to a significant demonstration of a lack of knowledge, skill or judgment towards a patient.* Incapacity generally refers to mental or substance abuse illness that impairs the practitioner's judgment.**

Reading the existing termination mandatory reporting obligation and the new facility mandatory reporting obligation together, the following points emerge:

1. If the association with the registered health practitioner is terminated, the terminating member must report the matter in all cases (including for professional misconduct, not just for incompetence or incapacity).
2. If the association is not terminated, professional misconduct itself does not have to be reported. Just incompetence and incapacity have to be reported.
3. If the association is not terminated, the member does not have to make a report, even for incompetence or incapacity, unless the member operates the facility where the other registered health practitioner works.

Members and facility operators need to be aware of these new mandatory reporting requirements.

*As of June 4, 2009, "incompetence" is defined in the *Health Professions Procedural Code* as follows:

52. (1) A panel shall find a member to be incompetent if the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted.

**As of 2007, "incapacity" is defined in the *Health Professions Procedural Code* as follows:

"incapacitated" means, in relation to a member, that the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member's practice be subject to terms, conditions or limitations, or that the member no longer be permitted to practise….

Suspended Members

The following members were suspended as of February 2, 2009 for failure to pay their fees for 2008–2009 in accordance with section 24 of the Health Professions Procedural Code:

ALSBERGAS, Marie Jeanette (1027)
BRANDER, Yasmine Margaret (2896)
DEVINE, Katie Lauren (4942)
GAREAU, Maureen Elizabeth (2634)
KUMAR, Jodi Nachreiner (4853)
LAMBA, Tanya (4994)
MACNAB, Jocelyn Ann (3319)
MAYER-LINKLATER, Estelle (3303)
PENNER, Karen Arlene (2089)
SINGER, Fanny (2823)
SIROIS, André (2307)

Part 2 of 3:
The Register

The register is the public record of information about individual audiologists and speech-language pathologists. One of the major features of the amendments to the *Regulated Health Professions Act* (RHPA) is the increased information about members that will be available in the public register. In making these amendments, the government expressed the desire that the public have access to more information about health care practitioners so that the public could make informed choices.

While there is an increased emphasis on transparency and accountability of practitioners, there still remain some privacy protections. For example, the fact that a complaint has been made against a member (or even that a lot of complaints have been made against a member) will not be posted on the public register.

The list of publicly available information is too long to set out in this article. For a complete list see Section 23 of the RHPA as well as the CASLPO Bylaw that can be found on the CASLPO website www.CASLPO.com. However, the more significant items are as follows:

1. A member's name.
2. A member's business contact information
3. Any terms, conditions and limitations on a member's certificate of registration.
4. Any suspensions or revocations of a member's certificate of registration including for non-payment of fees.
5. Information about discipline and incapacity proceedings against a member.
6. Any finding of professional negligence or malpractice made by a court against a member.
7. Any additional information required by the Ministry of Health and Long-Term Care for human resource planning.

The public, including potential employers, obtain information about members through the College's register. The changes to the register affect both the amount of information available to the public as well as the overall accessibility of that information. Three of the most significant areas of change related to the register are as follows: (i) form; (ii) content; and (iii) permanence. In addition there are some new provisions protecting personal information about members in compelling circumstances.

Form

One of the biggest changes to the RHPA is the new requirement for every College to post its entire register on its website. This will allow the public to view all of the register information about every member directly through the Internet. In addition, the new legislation will require the College to advise individuals who inquire about a member, whether in person, by phone, letter, email, or through the College's website, of all of the register information that is available regarding that member. In other words, the inquirer does not have to know what to ask for; the College must actively assist the inquirer to locate the information that will help him or her.

Content

In addition to the information already required for the register, several new categories of information will be added on June 4, 2009. These include the following:

(i) referrals to the discipline committee (currently information only has to be included in the register after a finding is made although many Colleges posted the dates of upcoming hearings shortly before they commenced);

(ii) a synopsis of every finding made against a member by the Discipline Committee or the Fitness to Practise Committee (currently only the actual sanction or order is recorded on the register and discipline summaries are found elsewhere on the College's website);

(iii) findings of professional negligence or malpractice made against the member unless the finding is reversed on appeal (currently this information is not collected by the College or posted on the register); and

(iv) a notation of the resignation and agreement where a member, during or as a result of an investigation, has resigned and agreed never to practice again in Ontario (currently this is only done if the member consents or the matter has gone to the Discipline Committee).

Permanence

One of the most significant changes to the current register requirements relates to the length of time that information is expected to remain on the register. Under the current RHPA, a significant portion of a member's history with respect to most discipline and/or fitness to practice proceedings would automatically be removed from the register after six years. Under the new provisions, however, all register information remains posted indefinitely, subject to a few limited opportunities for the member to ask for the information to be removed. In essence the member has to go through a pardon-like process asking for the information to be removed. The committee imposing the order would have to consider whether the removal of the information is consistent with the public interest. In discipline matters, a pardon is only available where the sole sanction was a reprimand or a fine. A pardon is not available for any finding of sexual abuse.

Personal Safety and Other Compelling Concerns

There are some exceptions to the duty of the College to post information about members on the public register. The major one is where the information would jeopardize the safety of any person. For example, if a member is being stalked, the Registrar can withhold contact information from the register and the public. Non-contact information would still be included on the register (e.g., any terms, conditions and limitations on the member's registration). However, the Registrar can only do this if he or she knows about the concern and has reasonable and probable grounds to support the request. It is important for members who feel that their safety, or anyone else's safety, would be jeopardized by the public register provisions to notify the Registrar of this concern with any supporting documentation.

In addition, the College can only put on the register the minimum personal health information about members necessary to protect the public interest. For example, if a member is incapacitated, details of the nature of the incapacity are unlikely to be placed on the register. Often only the fact that there has been an incapacity finding made and the nature of the terms, conditions and limitations needed to protect the public interest (e.g., the member must work with a colleague) is sufficient to protect the public.

The Registrar also has the ability to withhold information from the register that is obsolete and no longer relevant to the member's suitability to practice. This is intended to be a narrow exception. An example might be removing from the register a finding against a member for conduct that is no longer prohibited (e.g., an old advertising infraction for a type of advertisement that is now permitted).

Members should appreciate that their professional lives will be more transparent than ever after June 4, 2009.

Part 3 of 3:
The Inquiries, Complaints, and Reports Committee

Under the current RHPA, concerns about members are investigated by three internal bodies, the Executive Committee (for non-complaints investigations), boards of inquiry (for incapacity concerns) and the Complaints Committee (for formal complaints). Under the new legislation, these investigative functions have been merged into one committee, the Inquiries, Complaints and Reports Committee (ICRC). As a result, the ICRC will see all complaints and will also screen all member-specific concerns that arise from other sources, including mandatory reports.

Although there are many significant process changes that have resulted from the creation of the ICRC, four areas of change that will be of particular interest to members relate to: (i) notice requirements, (ii) use of a member's prior history, (iii) alternate dispute resolution procedures and (iv) the dispositions available.

Notice Requirements

Under the new legislation, members will receive notice of a complaint within 14 days of it being filed with the College and will receive notice of a Registrar's investigation report to the ICRC within 14 days of that report being filed with the committee. Particularly for complaints, members will therefore be alerted early on about the concerns so that they can prepare for the investigation while the matter is still fresh in their minds. The notice will also contain formal notice of their right

to respond in writing to the concern. In addition, for complaints the notice will also contain the timelines that apply to the investigation and the right of an independent review of the ICRC decision by the Health Professions Appeal and Review Board (the Board).

Complaints are to be investigated within 150 days (up from 120 days). Where the ICRC has not rendered its decision by then, it must send a letter to the parties notifying them that it has not completed the matter and that it will try to do so within a further 60 days. After day 210 the College must send a letter to the parties (and to the Board) every 30 days explaining why the complaint has not been decided yet. Either party can then go to the Board for an order directing the ICRC to complete their investigation promptly or for the Board to take over the investigation. One of the implications of these timeline requirements is that Colleges will be less likely to agree to lengthy delays in the investigative process (even if requested by the member – for example, if there is a parallel criminal proceeding).

Prior History

In addition to receiving notice of the complaint or report, the new legislation also requires members to be given copies of their available prior history with the College. The ICRC is required to consider and review that prior history when looking at new concerns. The prior history includes any earlier decision of the Executive, Complaints (except for frivolous and vexatious matters), Discipline or Fitness to Practice Committees. Even prior decisions dismissing a complaint or concern need to be reported. The prior history rule attempts to ensure that the ICRC has the complete picture of the member's professional career so that new concerns are not dealt with in isolation. For example, if a member has a history of standard of practice concerns, none of which are disturbing on their own, but collectively raise serious concerns about the member's competence, the ICRC can take this into account.

The member will, of course, be able to respond to the prior history. For example, the member can make written submissions placing the prior history in context (e.g., if the nature of the member's practice generates a high risk of dissatisfied patients) or indicating that the prior history may have little or no relevance to the current concern.

In complaints matters, however, there is a possibility that the prior history may become known to the complainant. This may occur if the member's response to the prior history is given to the complainant by the ICRC. It may also occur if there is an appeal to the Board for a review of the decision of the ICRC (as the Board often discloses the entire ICRC file to both the complainant and the member). Members with a significant prior history may wish to seek professional assistance in dealing with this possibility.

Alternate Dispute Resolution

While Alternate Dispute Resolution (ADR), or informal resolution, has been a common practice at many Colleges for some time now, formal rules have now been developed. These rules apply only to the use of informal resolution processes in formal complaints. Non-complaint investigations or complaints after they have been referred to discipline may still be dealt with flexibly by the internal processes selected by individual Colleges.

These rules for informal resolutions of formal complaints include the following:

1. The Registrar must initiate the process.
2. The consent of both parties is needed before ADR can begin.
3. ADR cannot be used in a complaint involving sexual abuse.
4. All communications in the ADR process must be kept confidential and privileged and cannot be used in other proceedings, including discipline.
5. If the ADR is unsuccessful, the facilitator cannot participate in the remainder of the ICRC process.
6. Any resolution must be ratified by ICRC to ensure that it is in the public interest.

Dispositions Available

Where there is no successful resolution of matters, the ICRC will have significant new options for disposing of the matters that it reviews. For example, the ICRC will now be empowered to require members to complete a specified continuing education or remediation program to address practice concerns. This could include, for example, successfully completing a continuing education course or a mentorship program. Even certain self-study programs could be ordered (e.g., to read and summarize, to the satisfaction of the Registrar, certain standards, guidelines and policies of the College). However, this new power means that the ICRC can no longer refer members to the Quality Assurance Committee.

In addition, the ICRC will be able to require members to attend before it for an oral caution in all matters, not just formal complaints.

The ICRC will also deal directly with incapacity matters. Under the current legislative scheme, the Executive Committee deals with incapacity matters by appointing a board of inquiry to inquire into a member's health. The results of those inquiries are then reported back to the Executive Committee which, depending on the information contained in the board's report, decides whether a formal hearing is necessary. Under the new legislation, however, a "panel" selected by the Chair of the ICRC will fulfill all of these functions directly.

Of course the existing options under the current regime remain available (e.g., dismissal of the complaint, referral to discipline and negotiating an Acknowledgement and Undertaking with the member).

The changes to the ICRC process will have an impact on members who face complaints or other formal investigations.

October 1, 2009 –
MARK THIS DATE FOR YOUR REGISTRATION RENEWAL!

This year, your 2009–2010 Registration Renewal is due on or before Thursday October 1, 2009.

Beginning in 2009, the College is required to collect additional information from members for health human resources planning for the Ministry of Health and Long-Term Care. As a result, you will notice that your renewal this year is much longer. Members must carefully fill out all sections of the new registration renewal form.

You can start to renew for 2009–2010 online at www.caslpo.com on **August 1, 2009**. You can also renew using a paper renewal form if you download CASLPO's 2009–2010 renewal package from our website on or after August 1, 2009. If you would like the College to send you a renewal package, you must make a request by telephone, email, or fax before September 18. After this date, a renewal package may not get to you in time by regular mail for you to meet the October 1 deadline

Please be advised that CASLPO does not allow a grace period. Renewals received after October 1 will incur a 20% late penalty. Renewals received after October 1 without a late penalty payment will not be processed.

To avoid delays and late fees, we encourage you to complete their renewal as soon as possible. If you choose to pay your annual fee by cheque, you may submit a completed renewal form and your post-dated cheque for October 1, 2009 well in advance of the renewal deadline. Your post-dated cheque will not be deposited until October 1, 2009.

If you are not renewing your membership, please notify the College in writing or complete the Resignation Section of the paper renewal application form and return it to the College on or before October 1, 2009. If you fail to renew your membership with the College and do not resign, your membership will be suspended for non-payment of fees.

Remembering Sonia Reichman

It is with great sadness that the College received the news in mid March 2009 that Sonia Reichman had passed away. Sonia had been involved with the College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO) for a number of years as a non-council committee member. She was appointed as a member of the Patient Relations Committee in 2001 and most recently as a member of the Speech-Language Pathology Practice Advisory Committee. Her service to the profession and the public of Ontario through her involvement with CASLPO will be remembered and appreciated.

Interprofessional Collaboration: Making It Happen

By Carol Bock, Deputy Registrar

In the last few issues of *CASLPO Today* you may have noticed a focus on interprofessional collaboration. That is no coincidence. It is a focus that the Ministry of Health and Long-Term Care has said is necessary in order for the health care system to be accessible, of a high quality, and to be sustainable. Interprofessional collaboration is not just another buzz word. The ultimate goal is a regulatory health care system that enables each of Ontario's thousands of health professionals to contribute to patient care to the full extent of their training and abilities, to collaborate with each other so that the efforts of all are deployed to produce the best possible results for patients, and to respond with up-to-date skills and a deep sensitivity to the rising expectations of today's health care consumers. This concept nicely dovetails into our College's ongoing efforts to promote collaboration (e.g., we are the only College that has position statements on collaboration, both within and between our health professionals). However, now we can move forward and expand the concept to go beyond clinical collaboration into collaboration between regulated health profession Colleges.

CASLPO is one of the first of the regulated health care professional Colleges to take that first step and test the waters of "College collaboration," which is definitely unchartered territory. Our membership has told us of many areas where there are barriers and opportunities for collaboration, including autism, dysphagia, CCAC services, etc. These are service areas where many health professionals are involved and have skills and knowledge that are integral to effective service to the patient/client but the scopes of practice and/or individual skill sets are not always maximized. This is the case for our profession, as well as the other health care professionals on these teams.

Of these service areas, dysphagia seemed to hold precedent-setting potential. It is an area where there are many health professionals involved at all levels of health care, including physicians, both GPs and specialists, there are nurses, nurse practitioners, occupational therapists, physiotherapists, dieticians, and speech-language pathologists. The skill sets within each of these professions as outlined by their scopes of practice, often overlap across the professions. In addition, our membership told us, there are varying skill sets independent of the particular profession and more dependent on the individual knowledge and experience.

To get a current idea of the "state of the practice" as it stands, we distributed a survey to our membership that you may have seen. We received an impressive response in a short turnaround time. Over 250 speech-language pathologists provided detailed answers to our questions in a two week timeframe (thank you to all who participated!). The results of that survey both underscored the impressions we already had and highlighted a few more issues to be considered. We surveyed our membership regarding present barriers to and opportunities for improved services. What emerged were many issues common to all the health professions involved in this service area, including barriers such as, making referrals to specialists, making referrals to other health care professionals, communicating a diagnosis, making a diagnosis, and ordering treatments. Many systemic issues that were specific to individual settings were also identified but common themes emerged and they generally related to lack of awareness about the skills, training and abilities each team member possesses and barriers related to more remote settings such as rural settings and at-home services.

With this information in hand, CASLPO has initiated the first step towards interprofessional collaboration by setting up a College-level forum discussion. In April we will be bringing together the College of Physicians and Surgeons of Ontario, the College of Dieticians of Ontario, the College of Physiotherapists of Ontario, the College of Nurses of Ontario, and the College of Occupational Therapists of Ontario to discuss the common issues affecting our members which we hope will lead to productive brainstorming around actions we as an interprofessional collective can take. We are excited to see what this initial meeting will produce and will keep you informed.

Orders, Directives, and Delegation of Controlled Acts

From time to time we get calls from members asking whether or not they need an order or a medical directive from a physician to perform certain tasks or whether they can accept an order or medical directive or a delegated controlled act to perform tasks.

The overarching principle that CASLPO members must apply in their consideration of performing any service is stated in our Code of Ethics:

Professional Constraints on Practice

Audiologists and Speech Language Pathologists:

2.2 will practice within the limits of their competence as determined by their education, training and professional experience;

2.7 will exercise independent professional judgment before implementing professional service/prescription

Controlled Acts

The *Regulated Health Professions Act* (RHPA, 1991), is based on a controlled acts model. The model is rooted on the premise that some health care procedures have a more significant risk of harm than other procedures. The RHPA lists 13 procedures that, if not performed correctly and by a competent person, have a high element of risk. These are known as controlled acts.

Audiologists are authorized to perform the controlled act of prescribing a hearing aid to a hearing impaired person. Speech-language pathologists are not authorized to perform any controlled acts except by delegation from a regulated health professional that can perform the controlled act being delegated. The college has two position statements dealing with delegation and acceptance of controlled acts.

The first deals with **Delegation of the Controlled Act of Prescribing a Hearing Aid for a Hearing Impaired Person**. This position statement states that audiologists must not delegate the controlled act of prescribing a hearing aid for a hearing impaired person to other individuals because delegation of this controlled act may result in serious risk of harm to the client. The risk of harm could arise from modifications that ultimately alter the output performance of the device when these modifications are not performed by authorized health professionals.

The second deals with **Acceptance of the Delegation of a Controlled Act**. CASLPO members may be asked to perform a controlled act. For example, in the course of practice, a speech-language pathologist may be called upon to accept the delegation of a controlled act; for example, putting an instrument, hand, or finger beyond the point in the nasal passages where they normally narrow and into an artificial opening into the body (RHPA, 1991). These acts would be delegated when performing such procedures as fiberoptic endoscopic evaluation of swallowing (FEES) or suctioning into a tracheo stoma.

CASLPO members may accept the delegation of controlled acts that are within the limits of their competence and under specific conditions documented in a delegator/delegatee agreement. It is the responsibility of the delegator to determine which controlled act procedures may be delegated, in consultation with those who will be involved with carrying out the controlled act. In addition,

a) there must be an order or a directive supported by a specifically outlined procedure

b) it is the clinician's responsibility to ensure that his/her facility provides appropriate support, safety procedures, and equipment to implement the procedure

c) only individuals who possess the knowledge, skill, and judgment to perform the controlled act procedure should do so

d) the decision to delegate should be made in the best interests of the patient/client

e) both the delegator and the delegatee are responsible for documenting the delegation and the conditions under which the delegation occurred

An analysis of potential harm associated with the performance of the controlled act must be completed prior to the acceptance of the delegation. Additionally, delegated individuals must be competent to

perform the controlled act. There must be informed consent by the client/patient and documentation of consent in the client/patient's records. The delegator remains accountable for the controlled act.

Orders and Medical Directives

CASLPO does not have any specific guidelines or position statements on requiring or accepting orders and medical directives except the overarching principle stated above. However, The Federation of Health Regulatory Colleges has developed "An Interprofessional Guide on the Use of Orders, Directives and Delegation for Health Professionals in Ontario." This guide has been developed to address questions regarding the use of orders and delegation to facilitate interprofessional care by health professionals practicing in any setting across the province. It has been developed as a consensus document by the Federation of Health Regulatory Colleges of Ontario and is designed to complement and assist with fulfilling guidelines, standards and regulations developed by each health profession college.

The guide is based on a framework of the fundamental cornerstones of health professional practice: patient interest and public protection achieved by regulated health professionals practicing independently and in teams in accordance with regulatory and legislative expectations for practice. The guide states that: "An order is a direction from a regulated health professional with legislative ordering authority (chiropodists, podiatrists, dentists, midwives, optometrists, physicians, registered nurses in the extended class, and those identified in regulation) that permits performance of a procedure by another. There are two types of orders, direct orders and medical directives.

Direct orders:

- are for a specific patient upon assessment by the physician/authorizer that the procedure is warranted;
- are also known by other names such as, requisitions, pre-printed orders/order sets, requests for consultation, doctor's notes and may be given as a referral for treatment; and
- are usually written but provision has been made for telephone and electronically transmitted orders (regulations under the *Public Hospitals Act* [PHA]) and verbal prescriptions (provisions under the *Drug and Pharmacies Regulation Act* [DPRA]). Due to the potential for error and accountability issues, verbal orders are not recommended in multi-practitioner settings when an authorizer is present and able to write the order.

Medical directives:

- are given in advance by physicians/ordering authorizers to enable an implementer to decide to perform the ordered procedure(s) under specific conditions without a direct assessment by the physician or authorizer at the time;
- may authorize co-implementers, that is: one implementer may be responsible to determine when to implement the ordered procedure and another may perform it;
- implementers are not ordering a procedure when they implement a directive; rather they are implementing a physician or authorizer's order for a procedure;
- directives must have the integrity of a direct order, thus physicians or authorizers potentially responsible for patients who will receive care under a directive must approve it;
- are approved only when all affected regulated professionals and relevant administrators participate in their development; and
- are always written and have essential components.

Of note, an order is for a procedure, not for a regulated health professional. Regulated health professionals cannot be ordered to perform procedures and must first determine if performing the procedure is appropriate from their clinical perspective. If it is, they proceed. If not, they are expected to refrain from performing the procedure and to take the appropriate action to address patient interests.

When are Orders, Directives and Delegation Necessary?

Orders – direct and medical directives – and delegation are preconditions required by legislation, practice convention or circumstances to authorize and permit performance of certain procedures prior to performing them.

Orders are required by:

- **Legislation.** A number of provincial and federal health statutes identify when orders are required by law to perform procedures;
- **Practice Convention or Circumstances.** Health care teams in some settings may use orders to coordinate and ensure appropriate care when an order

is not required by law. For example, physicians may give orders for vital sign assessments or for post-operative mobilization as part of a medical plan of care. Orders from designated authorizers may also be required to qualify for certain health services and benefits.

Medical Directives may be used when an order is required and it is appropriate and in the patient's interest for designated implementers to implement the procedure without the authorizer's direct assessment at the time of implementation. Examples of when an order is necessary and a directive may be appropriate include authorizing dietitians to implement therapeutic diets for designated hospital patients, authorizing medical radiation technologists to administer contrast media to specific patients as part of a radiographic exam, authorizing nurses to administer analgesia to elective post-operative adult patients and authorizing respiratory therapists to adjust ventilators for patients in an ICU in accordance with conditions set out in the respective directives.

Under the RHPA, there are specified circumstances called *exceptions* and exemptions when orders and delegation are not required where they otherwise would be. In some circumstances, a number of pieces of legislation may apply and authorization may be required in one but not another. When authorization is required in one piece of applicable legislation but not another, authorization is required. For example, the RHPA does not require respiratory therapists to have an order for tracheal suctioning; however, under the *Public Hospitals Act*, an order is required, thus respiratory therapists require an order when performing tracheal suctioning in a hospital.

In addition to legislative preconditions for orders and delegation, there may be setting-specific preconditions that apply as well. For example, the authority to become involved in care and authorize or perform procedures may flow from privileges, appointments, role descriptions, care assignments, care delivery models and policies and procedures within the setting.

CASLPO members are encouraged to review "An Interprofessional Guide on the Use of Orders, Directives and Delegation for Health Professionals in Ontario" that is available on The Federation of Health Regulatory Colleges' website at www.regulatedhealthprofessions.on.ca.

Conclusion

CASLPO members should consider the various requirements relating to delegation and acceptance of Orders, Directives, and Controlled Acts and ensure they comply with the relevant legislation, CASLPO requirements and practice setting preconditions. They must always practice within the limits of their own competence and put the interest of their patient/clients first.

Health Professions Database: Better Information for Better Health

The College of Audiologists and Speech-Language Pathologists of Ontario, the Ontario government, and 18 other health professional regulatory Colleges are working on a project to learn more about you. The expected result – improved health care for Ontarians.

The Ontario Ministry of Health and Long-Term Care is working with Colleges such as the College of Audiologists and Speech-Language Pathologists of Ontario to create the Health Professions Database. The ministry and colleges are collecting demographic, education and employment information from health professionals across the province.

"We're building improved evidence so we can all make better decisions to promote the right supply and mix of health professionals," says Jeff Goodyear director of the Health Human Resources Policy Branch for the Ministry of Health and Long-Term Care. "We're looking forward to learning more about health professionals and working with them so we all can help provide better patient care and access to care."

Regulatory colleges, professional associations, government, researchers, post-secondary institutions and

Local Health Integration Networks will all use the information from this database. They'll use it to shape research, policy and programs that will help build stronger healthcare teams. All of this will help toward offering you the best work environment possible so you can continue to serve the people you care for.

The Health Professions Database will be used to explore questions such as: Where do health professionals work? How many may retire over the next few years? How many work full-time and how many work part-time? What type of care do they provide?

The information for the Health Professions Database will come from professionals like you through registration renewal forms. So there will be more questions on the next form than previously

"Some of the questions may seem simple, but they're important," says Goodyear.

"We know you're providing the absolute best care possible for the people you serve. Now we all need to work on making the best health care system possible. And we need your help."

Protecting CASLPO's Assets

We are pleased to announce that for the seventh year in a row, there will be no increase in College membership fees.

By Gregory P. Katchin, CASLPO Director of Finance

As we are all well aware, the economy, not only in Canada but globally, is in a state of crisis. Many of the world's major financial institutions have collapsed or been bailed out. We all face financial challenges.

One of the last things you probably worry about is whether or not the financial crisis is impacting CASLPO. Well, we worry about it and we are pleased to say that as we approach the mid-point of your College's financial year, we are meeting the challenges head on and remain on secure financial footing.

With several months behind us, membership fee revenue remains on budget. And, through careful and ongoing cost control and containment, we have kept expenses under budget, providing the College with a slight financial cushion as we face the remainder of the year. Each and every expense is scrutinized, and best prices are constantly sought. **Because of this, we are pleased to announce that for the seventh year in a row, since September 2002, there will be no increase in College membership fees.**

CASLPO is also working to safeguard its assets. Your College's primary financial assets are its investments, and these remain sound. The College has an investment policy that restricts the types of eligible investments in which the College may invest its funds that are not immediately required. Consequently, your College holds investments in:

1. bonds, debentures, or other evidences of indebtedness guaranteed by the Government of Canada, the Government of Ontario, or the Government of another province of Canada; and
2. deposit receipts, deposit notes, certificates of deposit, acceptances, and other similar instruments issued or endorsed by a bank chartered under the Bank Act or a trust company insured under the Canada Deposit Insurance Corporation.

The College manages the interest rate price risk exposure of its fixed income investments using a laddered portfolio with varying terms of maturity. This helps to enhance the average portfolio yield while reducing the sensitivity of the portfolio to the impact of interest rate fluctuations. Current investments are in general earning interest in the 4 to 6% range.

In these trying economic times for everyone, Council and staff remain committed to managing and safeguarding our assets and our future.

The ABCs of QA

By Carol Bock, Deputy Registrar

Spring means melting snow and blooming tulips to most but here at CASLPO it also means the rolling out of the Quality Assurance Program. Early in January, 250 members were randomly selected (Selections are generated by an off-site computer in order to ensure they are truly randomized) to submit their Self Assessment Tools (SATs) and 30 of those members were randomly selected to participate in the peer assessment process. Once we request members to participate in the Quality Assurance Program, the phone starts ringing with many common questions. Read on for the ABCs of QA.

Quality assurance in the broadest terms is defined as a planned and systematic approach to monitoring, assessing and improving the quality of products or services on a continuous basis within the existing resources. Within the context of health care, and more specifically, speech pathology and audiology, the definition is easily modified to:

> A planned and systematic approach to monitoring, assessing and improving the quality of *speech, language, and audiology* services on a continuous basis within the existing resources

In the regulated health professions, quality assurance is mandatory. *The Regulated Health Professions Act*, 1991 dictates that we must have in place a quality assurance program in order to be self-regulated and that the program must consist of:

- continuing education and professional development;
- self, peer and practice assessment; and
- a mechanism for the College to monitor participation and compliance.

CASLPO is often asked, "who decides the details of this program?" The answer is the Council of the College, which is made up of members of the profession you elect, along with members of the public appointed by the government of Ontario, and academic members. The Council members look at the quality assurance regulations that are specified in the RHPA and decide how they will implement and administer them.

At CASLPO, the Quality Assurance Program involves four facets. We have the Self Assessment Tool, the Continuous Learning Activity Credits (CLACs), which is your continuing education and professional development, the Peer Assessment Program, and the Practice Standards.

Self Assessment Tool (SAT)

The guide for the SAT will direct you to evaluate five Professional Practice Standards, which are:

- Management Practice
- Clinical Practice
- Patient/Client Centred Practice
- Communication
- Professional Accountability

You are expected to complete the Self-Assessment Tool every 3 years and to review the Continuous Learning Activities every year. Members should note that CASLPO has now put everybody on the same 3-year cycle, which is currently January 2008 to December 2010. So at this point in time all members should have filled out the SAT, set goals for 2008, recorded their learning activities associated with each goal and rated their progress and impact. All members should also have set their goals for 2009. If you happen to be randomly selected to submit your SAT, CASLPO will review the SATs to collect aggregate data and determine if it is complete. However, they will not be individually evaluated. It is designed to be a tool for *self*-assessment and as such not subjected to evaluation by anybody other than you. If you are randomly selected to submit your SAT, you do *not* need to submit your evidence of compliance.

Continuous Learning Activity Credits (CLACs)

To accumulate your 45 credits over 3 years, you need to first identify three or more Learning Goals that relate to your self-assessment and your professional practice. These goals are generally broadly stated goals that provide a rationale for participating in continuous learning. Learning Goals can be related to a specific indicator within a standard (see the five standards listed above), they can be unrelated to the indicators or they can be added as a result of a learning opportunity that arises. Your learning activities will then be categorized according to these Learning Goals. Not all activities qualify as a credit and there are restrictions on the number of CLACs that can be claimed for some activities so consult the guide.

Peer Assessment Program

Members are randomly selected from the 250 members who submit their SAT to participate in a peer assessment. Great efforts are made

to ensure that this is a positive learning process. The large majority of the membership is found to be compliant in all areas. In the instances where partial or non-compliance is identified, the Quality Assurance Committee will request further information and/or action. However, our Peer Assessors are practicing clinicians and come to the process with a strong sense of what is practical and reasonable. They may be your best "mentor."

There are four phases to this process:

- You submit your SAT *and* your evidence of compliance
- You are then paired up with a Peer Assessor (based on your population of patient/clients, location, etc.), who reviews your evidence and arranges a site visit. The member has the opportunity to veto one peer assessor, if they so choose.
- A site visit is conducted, which involves a file review and discussion around practice issues as well as a review of any onsite evidence.
- The Peer Assessor then submits a report on the details of your self-assessment, your evidence of compliance and the information discussed at the site visit. You have the opportunity to read this report and respond prior to when the Quality Assurance Committee reviews it. The Committee looks at all the information gathered, including your response if you had one, and determines if all is going well with your practice, or if you would benefit from some sort of follow-up actions.

Practice Standards

These are important documents that guide your practice and contribute to ensuring a quality practice. As such, each member must take the time to read, understand and follow them. They include (and can be found at www.caslpo.com):

- Preferred Practice Guidelines (PPG's) and Practice Standards and Guidelines (PSGs)
- Position Statements
- Code of Ethics
- Sexual Abuse Prevention Plan
- Infection Control

As of April, CASLPO is well underway with the annual Quality Assurance Program. However, we are always interested in your feedback in order to make a program that works for you. If you have any questions or comments, please contact Carol Bock, Deputy Registrar at cbock@caslpo.com.


Lynne Latulippe

Lynne Latulippe leaves CASLPO for the College of Teachers.

Lynne joined CASLPO in September 2002 in the position of Professional Practice advisor. Her responsibilities included program development and support, policy development related to professional practice issues, and advisory services and other support to assist the members to comply with the regulations and provide quality care. Later, Lynne took on the responsibilities associated with the complaints and discipline processes of the College and was promoted to Manager of Professional Conduct. Most recently while Barbara Meissner Fishbein was ill she also took on the Quality Assurance Program. She was a valued member of the CASLPO staff team and her contributions to the success of the college will be remembered. She has left CASLPO to join the College of Teachers of Ontario in the position of Manager of the Investigations Unit. We thank Lynne for her years of service to CASLPO and wish her well in her new position.

2009 Professional Statistics

The following information is based on data as of March 2009 from members reporting on their primary businesses. CASLPO currently does not collect information on secondary businesses.

CASLPO membership consists of 548 audiologists, 2,616 speech-language pathologists and 11 individuals registered to practise in both professions.

MEMBERSHIP BY CATEGORY

	GENERAL (%)	INITIAL (%)	ACADEMIC (%)	NON-PRACTICING (%)	LIFE (%)
Audiologists	90	5	1	3	1
SLP	89	4	1	5	1

MEMBERSHIP BY AGE OF CASELOAD

	PRESCHOOL (0–5 yrs) (%)	SCHOOL AGED (6–17 yrs) (%)	ADULTS (18–64 yrs) (%)	GERIATRIC (65+) (%)
Audiologists	26	36	19	19
SLP	38	39	13	10

MEMBERSHIP BY SETTING FOR PRIMARY BUSINESS

	Audiologists (%)	SLP (%)
Hospital	20	16
CCAC/Home Care/ SHSS	0	13
Long Term Care	1	1
Specialized Centre	3	2
Adult Rehabilitation Centre	1	4
Industry	5	0
Children's Treatment Centre	2	14
Public Health	2	1
Private Practice	55	10
Education	2	27
University	3	2
Preschool Initiative	0	7
Other/ Not Reported	6	3

MEMBERSHIP BY PRIMARY RESPONSIBILITY

	ADMIN (%)	CLINICAL (%)	CONSULTANT (%)	RESEARCH (%)	TEACHING/ ACADEMIC (%)
Audiologists	6	84	6	2	2
SLP	4	81	12	1	2

MEMBERS BY HOURS OF PATIENT CARE PER WEEK

	0 ≤ 8	> 8 ≤ 24	>24 ≤ 35	> 35
Audiologists	5	14	23	58
SLP	4	15	29	52

Languages in Which CASLPO Members Report Providing Service

Afrikaans, American Sign Language, Amharic, Arabic, Azari, Bangla, Bengali, Bulgarian, Cantonese, Chinese, Creole, Croatian, Czech, Dutch, English, Estonian, Farsi, Filipino, Finnish, Flemish, French, French Sign Language, Fujian, Fukien, German, Greek, Gujarati, Hakka, Hebrew, Hindi, Hokkien, Hungarian, Iranian, Italian, Japanese, Kannada, Kashmiri, Konkani, Korean, Lithuanian, Macedonian, Malayalam, Mandarin, Marthi, Nepali, Ojibwa, Panjabi, Persian, Polish, Portuguese, Romanian, Russian, Serbian, Sign Language, Slovak, Slovenian, Spanish, Swatow, Swedish, Tagalog, Taiwanese, Tamil, Telugu, Toisan, Tulu, Turkish, Ukrainian, Urdu, Vietnamese, Yiddish, Yoruba.

COUNTRIES WHERE INTERNATIONALLY EDUCATED/APPLICANTS WERE INITIALLY TRAINED

Applicants	Country of training (Canada excluded)	Number of applicants
Largest Number	United States	42
Second-largest number	Australia	6
Third-largest number	Ireland	4
Fourth-largest number	South Africa	2
Fifth-largest number	Iran, Egypt, UK	1 each

JURISDICTION WHERE MEMBERS WERE INITIALLY TRAINED

Jan 1 to Dec 31	Ontario	Other Canadian Provinces	USA	Other International	Unknown	Total
Total Members	1539	482	924	200	31	**3176**

APPLICATIONS PROCESSED

Jan 1 to Dec 31	Ontario	Other Canadian Provinces	USA	Other International	Total
New applications received	79	26	42	15	**162**
Applicants who became members	95	30	47	12	**184**
Applicants who were issued an initial certificate of registration	90	20	29	9	**148**

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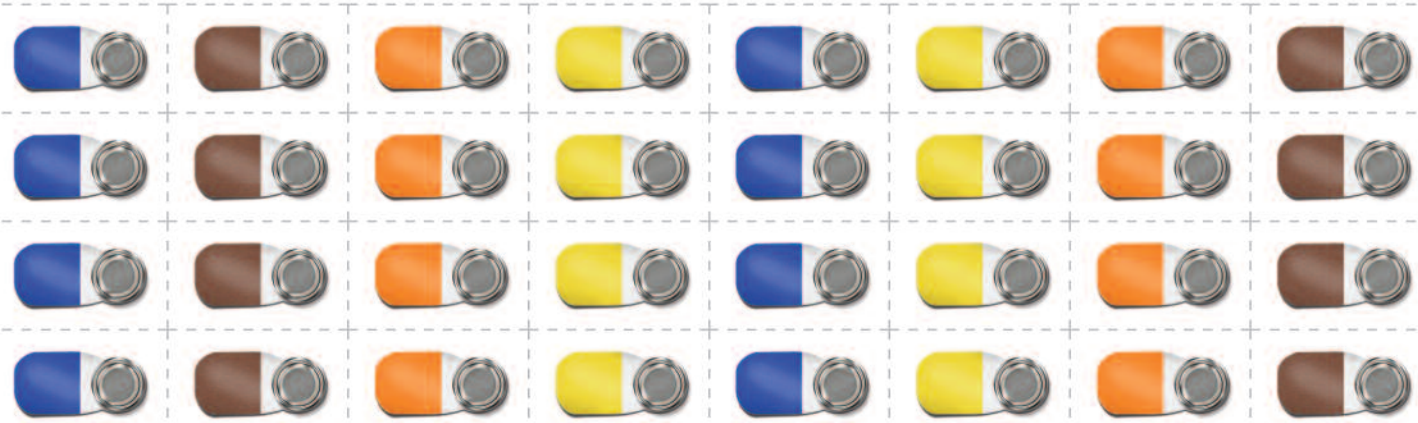


How Well Do You Maintain Professional Boundaries?

Part II: Discussion

By Karen Luker, Deputy Registrar

In Part I of this article, published in the February issue of *CASLPO Today*, readers were encouraged to consider the questions below related to their knowledge of professional boundaries. So how well did you do? If you answered "MAYBE" to all of the questions, you are likely aware of the importance of maintaining professional boundaries within the therapeutic relationship. In selecting a "maybe" answer, you will have recognized that boundary crossings can fall into a grey zone and that normally inappropriate behaviours may be acceptable if they meet the client's needs and goals. In this article, we discuss possible responses and special considerations.

Is it appropriate for me to touch a patient/client who is visibly upset after having been given bad news?

There are a variety of ways of using touch to communicate nurturing, understanding, and support such as a pat on the back or shoulder, a hug or a handshake. Such touch can, however, also be interpreted as an invasion of one's space or even a sexual advance. Using touch for supportive or therapeutic reasons necessitates careful and sound clinical judgment. Be cautious and respectful when any physical contact is involved, recognizing the diversity of cultural norms. In addition, work with children requires special consideration. Some agencies advise their staff to avoid any touching of children. In other settings, touching may be permitted, and this would ordinarily be open to public scrutiny. Ask yourself, "Would I do this in the presence of my colleagues or this child's parents?" Again, good clinical judgment should prevail for the protection of both the child and the practitioner.

Should I stay for dinner with a family whose child I have just seen for a session in their home? Can I accept a box of chocolates from this child?

It may be acceptable on some occasions to accept a modest gift from a patient/client during socially and culturally appropriate times. When deciding whether or not to accept a gift, you should consider: (a) the context of the situation or the occasion for which the gift is offered, its monetary value and appropriateness, (b) the client's intent in offering the gift, (c) whether the gift will change the nature of the relationship and impact on your clinical reasoning or decisions, (d) the policies of the organization for which you are working, and (e) whether the parents will expect a different level or type of care from you.

Is it appropriate for me to give a neighbour advice regarding her aging parent?

A professional living and working in a community will have a number of relationships, whether they are social or business-related. Audiologists and speech-language pathologists are often asked to give opinions or suggestions to members of the public because of their knowledge and experience. It may be appropriate for you to provide general information, such as basic facts about a communication disorder and the need to consult a professional under certain circumstances. It would not be considered appropriate, however, for you to provide specific recommendations such as the type of therapy which might benefit the person. Furthermore, unsolicited advice would not be acceptable under any circumstances.

Should I express my disagreement with another professional's opinion?

Expressing and resolving disagreements with other professionals are a

true test of boundary issues. There are situations where a member disagrees with another service provider on an aspect of patient/ client services, and the onus is on the member to make reasonable attempts to resolve these disagreements in the patient/ client's best interest. CASLPO's position statement, entitled "Resolving Disagreements between Service Providers" may serve as a useful guide in these situations.

Is it reasonable to consider lunch with a client who stutters a "transfer" activity?

Participation in outings with persons who stutter offers the speech-language pathologist the opportunity to observe a client's ability to implement techniques in a daily situation, where communication demands may be greater than in the clinic setting. It may be appropriate to attend a lunch if it serves its intended purpose (and addresses a specific objective or goal) rather than your own agenda. You may wish to ask yourself whether or not you would engage in this activity with other clients, and whether or not your employer is aware of this outing.

Is it acceptable for me to date a former patient/client?

In some situations, it is never appropriate to develop a social relationship with a former patient/ client as in cases where psychotherapeutic techniques have been used. In other situations, initiating a relationship may be appropriate. Consider the following factors: (a) the nature of the intervention that you provided, (b) the duration of the therapeutic relationship, including the possibility that you may be called upon in future to provide professional services or render a professional opinion, (c) the amount of time that has elapsed since the patient/client was discharged and the therapeutic relationship ended, (d) the degree, if any, to which the patient/client has developed an emotional dependency on you as a result of the therapeutic relationship, (e) the potential impact on the well-being of the patient/client, and (f) all other circumstances that bear upon the nature of the member-patient relationship that may affect the ability of the patient/ client to act freely.

Should I tell my client about my mother's stroke and the services she obtained in the community?

It is normally inappropriate to engage in routine disclosure of details of your personal life. However, there may be occasions where you may choose to disclose personal information to a client if you believe the information will assist in meeting his or her therapeutic needs. In this example, it may be appropriate to suggest a service option such as a conversation group or social club that your mother enjoyed. It would not be considered appropriate, however, to insist that your client see a specific speech-language pathologist in private practice who was especially helpful in your mother's situation.

Can I discuss my colleague's peer assessment?

Regulated health professionals often work very closely together and have many opportunities to discuss a number of topics, both work-related and not. Boundaries can easily be crossed, which in turn may lead to an unhealthy work environment. You should first establish the reasons for this discussion and the parties who are privy to it. Is the colleague who is undergoing the assessment asking for advice? Are you telling co-workers how you think your colleague will perform during his assessment in his absence?

Discussing the self-assessment and peer assessment programs with colleagues can be an extremely rewarding and productive exercise. It can form the basis for changes in policy, increases in efficiency, and confirmation that you are in fact complying with CASLPO standards. If you are considering discussing a particular person's assessment, it should probably be held in the presence of the individual in question.

Can I offer free follow-up services to a client who has been discharged because my agency's funding is no longer available?

There are several questions that you should ask yourself in this situation. What is your role as a client advocate in this situation? Are you crossing a boundary of providing high level, compassionate care? What are the possible benefits to the client? To you? What are the possible harms? How does your employer expect you to act in this situation? Are there other options you could explore?

In this situation, it is obvious that the client's needs are important, but so are yours and your organization's. Some clinicians might respond by donating increasing amounts of personal time and energy, even to the point of personal exhaustion. This action may result in a decreased ability to provide needed care over time. It is also possible that extra care will occur at the expense of other clients and the rest of the team.

Can I provide services to my nephew?

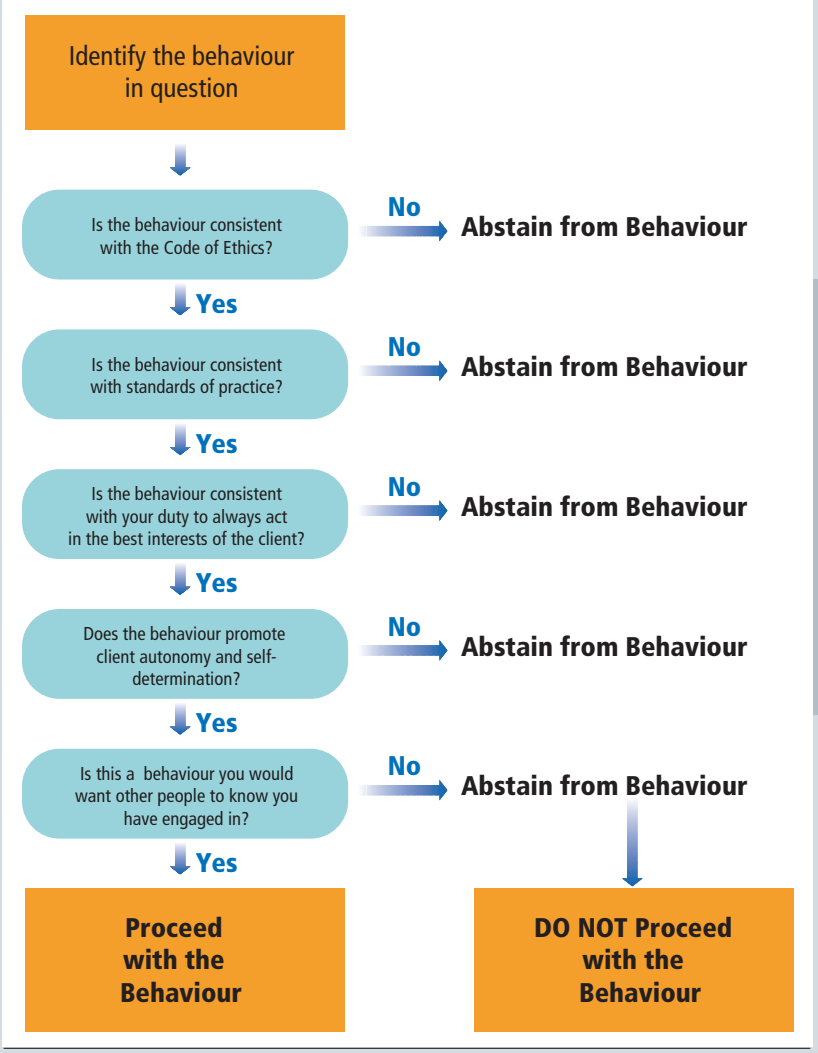
Treating members of your family, friends, or acquaintances is not the preferred option because of the difficulties inherent in managing the

boundaries of dual relationships. However, you may, in special instances, provide services if attempts to obtain them from other providers have been exhausted or no other options are available. It is always expected that you will provide high-quality care without compromising your professional judgment, and that you will take steps to communicate the limits of the therapeutic relationship. If you determine or anticipate that boundaries cannot be established or maintained, services should not be offered. Keep in mind that individuals viewing the dual personal- therapeutic relationship may view it as a conflict of interest and disallow it. You must therefore pro- actively manage the situation by disclosing the situation to your employer, payers and relevant others.

DECISION-MAKING FRAMEWORK FOR APROPRIATE PROFESSIONAL BEHAVIOUR

The College of Registered Nurses of Nova Scotia has developed a framework to assist nurses in determining if a behaviour is appropriate:

Figure 1.



From: Professional Boundaries: A nurse's guide to the importance of appropriate professional boundaries, National Council of State Boards of Nursing, 1995.

This framework, coupled with the "Boundary Crossings" questions proposed in Part I of this article, should guide you. The following documents, produced by CASLPO and available online and in your Desk Reference, will also be of assistance:

- Code of Ethics
- Professional Misconduct Regulation
- Proposed Regulation for Conflict of Interest
- Position statement on Professional Relationships and Boundaries
- Position statement on Resolving Disagreements between Service Providers

You may also call CASLPO at any time to discuss issues related to the therapeutic relationship and professional boundaries.

CASLPO wishes to acknowledge the College of Physical Therapists of Alberta for access to their document: "Therapeutic Relationships: Establishing and Maintaining Professional Boundaries: A resource guide for physical therapists".

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