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AUGUST 2009

CASLPO TODAY

Unforgettable

Memorable Clients
Who have Touched
Member's Lives

The Age of the
Electronic Health
Record

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I suspect all of us had that feeling at one point in our professional careers that it just might be easier/better/more rewarding/less hassle, to “slug coffee or flip burgers.” We have all had those “bad days” and “difficult clients” who have prompted us to question our commitment to our profession. Fortunately, for many of us those days have been “fleeting” and we have “carried on.” When we do take the opportunity to reflect on not only the challenges but the rewards, it often re-confirms our commitment to our professions.

In this issue, on page 24, you will read some poignant accounts of how some "Unforgettable" patients/clients have impacted the lives or made a significant impression on those with whom they have worked. I know these accounts will trigger your own thoughts and memories and, as is often the case, serve as a reminder as to why you entered the profession.

My own account of my “special moment” came to me last week as I participated in a celebration marking the end of this school year. The choir consisted of a number of students from one of the nearby elementary schools and included two older students who had been working with them. Both of these students have limited verbal skills and participated through signing each and every song. Not only did these students proudly sign but, the entire choir signed as they sang as did many people in the audience. It was truly amazing.

This practice of “inclusive communication” began along with the philosophy of “inclusive education.” For me, it began when a parent of a student with whom I was working found me in a school and, with teary eyes and emotion in her voice said: “Thank you for giving me the gift of being able to communicate with my son for the first time in his life. He just signed what I think was ‘red dog’ to me. I know that is his favourite book and he wanted me to read it to him. That has never happened before.” That was 25 years ago. We now have signing/singing choirs, class presentations using symbols and voice output devices and students who truly belong. Please take time to reflect for yourself and celebrate, as you read the accounts of others, how truly “life altering” your contributions have been.

When the last edition of *CASLPO Today* came out, one of my colleagues told me: “I read it cover to cover because I didn’t want to miss anything.” I would encourage you to do the same. There is so much happening professionally and you want to make sure you are “in the know.” This publication is a wealth of information.

In closing, I am happy to report that I have the privilege of being your President for the next year. You have my assurance that I will work to serve you well.

*Meg Petkoff,
President CASLPO*

June 2009 Council Highlights

Council held its regular meeting on June 5, 2009. The following are the highlights.

- Council approved a guide for SLPs in school boards in principle for consultation with stakeholders.
- Council discussed various issues relating to labour mobility and requested the Registrar to monitor the legislation as it is considered by the Ontario Legislature and report to the September Council meeting.
- Council discussed matters related to the formation of the Inquiries, Complaints, and Reports Committee (ICRC). Council approved that the composition of the ICRC would be eight including the Vice Presidents of Audiology and Speech-Language Pathology. It was agreed that the ICRC would investigate the establishment of 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. It reviewed the comments from members. It was decided that a further in-depth review of all bylaws and governance policies would be made.
- The election of officers was held and the results are as follows:
 - Meg Petkoff, SLP from Hamilton, was acclaimed as President.
 - Nancy Blake, SLP from Fergus, was elected Vice President of Speech-Language Pathology.
 - Sasan Borhani, Audiologist from London, was acclaimed as Vice President of Audiology
 - Vicky Papaioannou, Audiologist from Mississauga was acclaimed as audiology executive committee member
 - Pauline Faubert and John Krawchenko were elected as public members of Executive.

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.

Changing the Record

By Carol Bock, Deputy Registrar and Karen Luker, Deputy Registrar

“To err is human, to forgive divine.” We have likely heard this famous quote from Alexander Pope many times due to the simple fact that we all make mistakes – it’s a given. However, in our professional lives, forgiveness is not the only thing we seek. When our reports and records contain mistakes, we are required to correct the error and to do so in a certain manner. Further, clients are now able to review their records and request changes that we may or may not agree with. There are specific details in the PHIPA legislation as well as CASLPO’s Records Regulation that clearly direct our actions in this matter. Consider the following recent practice questions:

Situation 1

My client has pointed out that I made an error in the assessment report I provided. I inadvertently reversed the month and day of their child’s date of birth. Do I need to have them make a request in writing to amend this or can I just go ahead and make the changes and give them the modified report?

Patient/clients may request alterations in their record. PHIPA states:

“If the individual makes an oral request that the health information custodian correct the record, nothing in this part prevents the custodian from making the requested correction.”

In this situation the change in information is undisputed so there is no need to have the family put the request in writing. Certainly you can and should make the appropriate change and provide the family with the modified copy. Further, you must make the change in the patient/client’s record in a manner that does not obliterate the original information. In this situation, it would be simple enough to cross out the date stated and write the correct date. An effort should also be made to provide a note of correction to any other recipient of the report.

Situation 2

I am a supervising clinician in a private practice and I worked with a staff speech-language pathologist, hired as an independent contractor, who has since moved to another job. Upon reviewing a report he had written and meeting with the family involved, I realized that his assessment was conducted through translation but this was not mentioned in the report. I feel this is a significant omission. What should I do to correct the information?

Because an independent contractor compiled and interpreted the information, it may be beyond your authority to correct. PHIPA states:

“...a health information custodian is not required to correct a record of personal health information if,

(a) it consists of a record that was not originally created by the custodian and the custodian does not have sufficient knowledge, expertise and authority to correct the record; or

(b) it consists of a professional opinion or observation that a custodian has made in good faith about the individual.”

However, you could suggest to the family that they contact the speech-language pathologist directly and request a change. It would also be advisable to contact the speech-language pathologist directly and discuss your concerns. It may be an oversight that he is prepared to correct. Regardless, if a correction is to be made, it must be done using the following procedure:

1. record the correct information in the record and,
 - (a) striking out the incorrect information in a manner that does not obliterate the record, or
 - (b) if that is not possible, labelling the information as incorrect, severing the incorrect information from the record, storing it separately from the record, and maintaining a link in the record that enables a person to trace the incorrect information, or
2. if it is not possible to record the correct information in the record, ensure that there is a practical system in place to inform a person who accesses the record that the information in the record is incorrect and to direct the person to the correct information.

Situation 3

I have a client that does not agree with my interpre-

tation of their child’s language abilities as outlined in my assessment report. They have asked that I change my report in a fashion that would communicate something I do not agree with. I have discussed my findings and the rationale behind my conclusions but they are still insistent that I change the report. Am I duty bound to amend the report to meet their request?

Not necessarily. PHIPA states that you are not required to change a record upon request if, “... it consists of a professional opinion or observation that a custodian has made in good faith about the individual.” So if you feel that the change would be contrary to your professional opinion, then you may follow the procedure for “refusal.” You must respond in writing within 30 days and the notice of refusal must give the reasons for the refusal and inform the individual that the individual is entitled to,

(a) prepare a concise statement of disagreement that sets out the correction that the health information custodian has refused to make;

(b) require that the health information custodian attach the statement of disagreement as part of the records that it holds of the individual’s personal health information and disclose the statement of disagreement whenever the custodian discloses information to which the statement relates;

(c) require that the health information custodian make all reasonable efforts to disclose the statement of disagreement to any person who would have been notified under clause (10) (c) if the custodian had granted the requested correction; and

(d) make a complaint about the refusal to the Commissioner under Part VI. 2004, c. 3, Sched. A, s. 55 (11).

Situation 4

At the school board where I work we have long wait times for psycho-educational assessments and the SLPs are being asked to modify their assessment recommendations to help reduce the demand for these types of assessments. Specifically, it has been suggested that we consider recommending a consultation with the resource teacher, who specializes in learning disabilities, prior to considering a referral to the psychologist.

As mentioned above, if changes to current reports are being considered, then the same principles apply. However, this appears to be a request for wording that

may or may not reflect the original intent of the SLP. Careful consideration of wording is important because other regulations could be implicated. For example, the Professional Misconduct Regulation indicates that the following is an act of professional misconduct:

(10) Failing to refer a patient or client to more appropriate service when the member is unable to provide adequate service or failing to refer a patient or client who requires additional services in other professional areas.

Also, the Code of Ethics states that members:

- 1.3 will be honourable and truthful in all their professional relations;
- 1.5 will respect the patients'/clients' right to participate in treatment decisions and to be informed of potential risks and benefits of treatment options;
- 2.7 will exercise independent professional judgment before implementing professional service/prescription;
- 3.2 will protect the health and well-being of their patients/clients and advocate for them when appropriate;
- 3.3 will utilize all possible resources to ensure that quality service is provided, acknowledging the need for referral in special cases;
- 3.5 will apprise patients/clients of programs and services from which they may benefit;

You therefore have an obligation to provide referrals as you deem appropriate, and cannot alter your recommendations to reduce the demand for assessments. However, if you believe that the modified recommendation responds to the needs of the specific student then the suggested wording may be adequate.

Discipline Decision

Summary of the decisions and reasons in the discipline hearing held on February 11, 2009 concerning Mr. Stefan Fridriksson, Audiologist

This matter came before a panel of the Discipline Committee at a hearing which was held on February 11, 2009.

Allegations

The Statement of Allegations enumerated elements of an advertisement published on behalf of Mr. Fridriksson in June 2007. It was alleged that Mr. Fridriksson had engaged in professional misconduct within the meaning of paragraph 34 (improperly permitting advertising with respect to the member's practice) of section 1 of Ontario Regulation 749/93 under the Audiology and Speech-Language Pathology Act, 1991.

Response to the Allegations

Mr. Fridriksson admitted engaging in professional misconduct on the basis of an Agreed Statement of Facts.

Evidence

An Agreed Statement of Facts, as approved by the member and the College, contained the following agreed upon facts:

- In June 2007, an advertising agency engaged by Mr. Fridriksson published advertisements in two newspapers in the Niagara region.

- In the advertisements, the following statements are attributed to Mr. Fridriksson: (a) "Anyone can sell hearing aids in Ontario," (b) "The dispensing, fitting and selling of hearing aids in Ontario is simply unregulated," (c) "Members of the public require a prescription to consult with a hearing instrument specialist whereas they do not require a prescription to consult with an audiologist," (d) "The primary concern of an audiologist is hearing health, not sales," (e) "Too often, unfortunately the most important qualification for an HIS (Hearing Instrument Specialist) is that they're a good salesperson, whose main goal is to sell more hearing aids. In this environment, quality of care and service is often not a priority," (f) "An audiologist has "passed a national competency examination," (g) "Unlike an HIS, an audiologist can't just 'make up' their credentials," (h) "In contrast to audiologists who are more concerned with a patient's overall hearing health, the focus for an HIS, 'can be on sales using high-pressure techniques,'" (i) "An audiologist will diagnose the problem, not just treat the symptoms," (j) "it's all about proper diagnosis."

During the proceedings, the panel was made aware that Mr.

Fridriksson published an apology and retraction in the respective newspapers in December, 2007.

Findings

The panel was satisfied that the conduct described in the Agreed Statement of Facts constituted professional misconduct as defined by paragraph 34 (improperly permitting advertising with respect to the member's practice) of section 1 of Ontario Regulation 749/93 under the Audiology and Speech-Language Pathology Act, 1991.

Penalty

The parties filed a Joint Submission on Penalty and Costs which suggested that the following penalty would be appropriate in the circumstances of this case:

- (a) Reprimand the member;
- (b) Require the member to pay the College's costs fixed in the amount of \$2,000.00 within three months from the date of the order;
- (c) Direct that the results of the proceeding be publicized through *CASLPO Today* and the public portion of the register, and that publication will include the member's name.

Decision on Penalty

The panel concluded that the proposed penalty was reasonable and in the public interest having regard to the facts of this case.

The panel, therefore, accepted the Joint Submission on Penalty and Costs and issued an Order as set out above.

The panel administered the reprimand at the conclusion of the hearing.

CASLPO 2009 Priorities

On Friday, June 5, 2009 members of the Council of the College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO) participated in their annual priority setting session. The purpose of the session was to examine issues and activities in order to set priorities for 2009/2010. The identified priorities will be used to develop a Workplan and Budget for Council consideration and approval in September 2009.

To set the stage for the discussion, the Council was reminded of the mandatory regulatory responsibilities, past year's priorities and recent environmental factors impacting the CASLPO direction and operations. The Council also reviewed the core values; mandate, mission, and objectives; core and discretionary activities; and current allocation of time and financial resources.

It was also noted that in 2009/10 CASLPO will be going through a transition, learning and adjustment phase. There will be a new Registrar and perhaps other new staff. There have also been major changes in legislation that will impact on the ability of the college to complete tasks that are not within its core regulatory mandate and activities.

1. Review the Self Assessment Tool and other QA program requirements and processes to ensure compliance with the revised QA Regulations and the Health Systems Improvement Act (Bill 171).
2. Undertake a major member education program regarding the new/recent PSGs including the development of an online webinar on consent.
3. Develop an online Self Assessment Tool that has the capacity to provide guidance as it's completed, can collect aggregate data, assists in goal setting, etc.
4. PSGs on;
 - Central Auditory Processing Disorders
 - Vestibular Function Testing
 - SLP roles in provision of services to individuals with autism
 - Assessment of adults by SLPs

Council will decide if and how to proceed in light of the commitment to other regulatory bodies and associations not to produce any new documents until the pilot project of the interorganizational group on infection control guidelines is completed in August 2009.

5. Pursue opportunities for interprofessional collaboration with other colleges and other professions.
 6. Review and provide comments to Council on the competency profile being developed for audiologists.
 7. Move the Public Awareness project forward with a specific request for funding for audiologists to provide hearing testing for persons less than 21 years of age.
 8. Review issues related to the Assistive Devices Program in terms of hearing aid corporations being authorized to dispense.
 9. Review CASLPO's position statement on the use of title doctor in order to add clarity and address issues which have come to light through practice calls and the complaints process.
 10. Develop a guide for members working in school boards distribute it to members and school boards.
 11. Develop a strategy and advocate for a significant role for SLPs in the provision of services to individuals with autism.
 12. Hold a conference in the fall of 2010 for members on regulatory matters.
 13. Develop a position statement and guide on electronic documentation.
 14. Complete the development of a Mentor Training Program.
 15. Develop a policy regarding language proficiency requirements for registration.
 16. Complete Registration Practices Audit required by Office of the Fairness Commissioner.
 17. Ensure a smooth transition to the Inquiries, Complaints and Reports Committee (ICRC).
 18. Develop guidelines related to various dispositions that are available to the ICRC with respect to complaints and reports.
 19. Ensure that bylaws and regulations and governance policies are updated and amended as necessary.
 20. Ensure Council is familiar with the revised Governance Policies and that Council adheres to its policies.
 21. Ensure that a plan is in place to hire a new Registrar in 2009.
 22. Ensure that Council (existing and 4 new members) is provided with educational opportunities on regulatory matters.
 23. Develop a government relations strategy at Queen's Park.
 24. Take a leadership role on regulatory matters across Canada through the Canadian Alliance of Regulators (CAR).
-

Labour Mobility

The Ontario Labour Mobility Act, 2009 was introduced in the Ontario Legislature on May 5, 2009 to implement full labour mobility for Canadian workers.

Amendments to the Agreement on Internal Trade (AIT) endorsed by Canada's premiers in January 2009 commit all provinces and territories to improving labour mobility for certified workers in professions and trades.

If passed, the legislation would establish a Labour Mobility Code to govern how Ontario regulators will support full mobility for out-of-province workers who are already certified. Regulators include all health regulatory bodies such as CASLPO as well as other professions like architects and engineers. The proposed legislation would ensure that a worker certified to practice in one province or territory will be entitled to be certified in that occupation in Ontario without having to complete additional material training, experience, examinations, or assessments.

The Act would recognize that Ontario regulators can set standards that are considered necessary to protect the public. At the same time, it would encourage regulators to work with their colleagues across Canada to achieve common standards, where possible.

Other key elements of the proposed legislation include:

- Allowing workers to apply for certification in Ontario without having to be a resident of Ontario.
- Allowing the responsible minister to review a regulator's practices and take all necessary steps to ensure those practices

comply with the Labour Mobility Code that is set out in the proposed Act.

- Enabling the Ontario government to impose fines on regulators who do not remove mobility barriers such as additional material testing and training, and to recover any fines imposed on Ontario by an AIT panel because a regulator did not work with the government to comply with the Code.
- Amending existing Ontario laws to conform to the Labour Mobility Code.
- Enabling the Ontario government to comply with the AIT's dispute resolution process.

If passed, the following provisions will take effect immediately upon the Act coming into force:

- The Act would override provisions in any other Act, regulation or bylaw that conflict with the Labour Mobility Code.
- The Act would apply to applications made on or after the day the Act comes into force or to any application where a final decision has not been made by that date.
- To make it easy for workers to get information, the Act would require regulators to publish on their websites all certification requirements for workers already certified in Canada.

Furthermore, if the Act is passed, regulators will need to amend any

inconsistent regulations and bylaws within 12 months of the Act coming into force.

Essentially this will mean that CASLPO and the other regulatory bodies in Alberta, British Columbia, Manitoba, New Brunswick, Quebec, and Saskatchewan must accept members in good standing from other regulated provinces without examination of their academic qualifications and without any requests for re-testing, retraining, or re-assessment. This is of some concern to CASLPO because currently in order to become a general member, who can practice independently, an applicants must have either practiced in Ontario as an Initial Practice Registrant and have successfully completed a minimum six-month mentorship program or have practiced in another jurisdiction for a minimum of two years. This applies equally to all Canadian and foreign-trained applicants.

These requirements are in place to ensure that new graduates or applicants who are practicing in other provinces or countries are competent to practice before receiving a general certificate that would allow them to practice independently. An "initial practice period" provides an opportunity for developing a firm foundation for effective independent practice. While the primary purpose is public protection, it also promotes professional development and quality service provision by members.

There is no registration exam for audiologists or speech-language

pathologists in Ontario or in any of the other provinces or territories. CASLPO's mentorship program which includes an assessment of the initial practice registrant's performance by a registered audiologist or speech-language pathologist at the end of six months utilizing a standard competency assessment tool is a fundamental component of our measures to protect the public. CASLPO's Initial Practice Registrant Program has been heralded as an excellent competency assessment process. CASLPO believes these requirements should be kept in place to meet the legitimate objectives of public safety and consumer protection.

CASLPO submitted a request for an exemption to allow us to continue to do this but this was turned down by the Deputy Minister of Health and Deputy Minister of Colleges Training, and Universities. This will

probably mean that the requirements in our registration regulation approved by the Government of Ontario for two years of practice experience or six months mentorship for all applicants for general registration will have to be eliminated for applicants from other regulated provinces. However, CASLPO plans to keep these requirements in place for all other new graduates or applicants from other unregulated provinces or countries to ensure that they are competent to practice independently.

This of course raises issues related to fairness in that a graduate from a university in Canada can become registered in another province and then come to Ontario after one day of experience, whereas if they apply directly to CASLPO they will have to go through the mentorship process. This would apply to inter-

national applicants as well.

One way to address this issue is for regulatory bodies to adopt common registration standards through a mutual recognition agreement that deals with new members post-August 2009. However, there must be some mechanism to ensure that regulatory bodies respect the MRAs and no changes are made without mutual agreement. Of course the problem with this solution is that it only takes one province to not agree and again, as we understand the AIT rules, we will be forced to accept the lowest standard in the country. CASLPO is working with other regulatory bodies across Canada through CAR to develop common standards based on the competency profiles.

We will keep the membership informed as the Labour Mobility Act is implemented.

Ontario Takes Key First Step in Addressing the Long Waits for Alternate Levels of Care

By Stephen McAteer, MBA, MHSc, SLP(C), Reg. CASLPO

Clinical Liaison, Wait Time Information Program

For all of us involved in the provision of health care, moving patients efficiently and effectively through our health care system can be a significant challenge. The difficulty we regularly face in transferring patients from one care setting to another has been a long-standing issue and results in a number of serious consequences, including compromising the availability of acute and post-acute care beds, increasing emergency room (ER) wait times and elective surgical cancellations, and limiting hospital surge capacity.

Understanding the factors that create these difficulties is critical to developing effective solutions. A new initiative is underway in Ontario to capture timely and reliable data on where patients are waiting in our healthcare system, why they are waiting and what types of services they are waiting for.

The term alternate level of care (ALC) is a clinical designation made by a physician and/or a delegate in collaboration with the interprofessional team, which would include audiologists and

speech-language pathologists. The goal is to identify patients who no longer require the intensity of resources or services provided in their current setting and are waiting for an alternate level of care. ALC patients often wait weeks, months, and sometimes years in acute and post-acute hospitals for transfer to an alternate level of care. This in turn prevents ALC patients from accessing services, such as rehab and community supports while also preventing other patients from accessing these beds and receiving care in a timely manner.

According to the Canadian Institute for Health Information (CIHI), in 2007 – 2008 ALC patients accounted for 5% of hospitalizations and 14% of hospital days in acute facilities across Canada, which equates to 5,200 beds in acute care hospitals being occupied by ALC patients on any given day. (CIHI; “Analysis in Brief - Alternate Level of Care in Canada”; January 14, 2009; pg. 3.)

The Ministry of Health and Long-Term Care (MOHLTC) is implementing a number of initiatives to reduce ER/ALC wait times; however, it has become evident that to make significant progress in this area, timely and reliable data on ALC patients in all acute and post-acute hospitals in Ontario is needed. To do this, the Wait Time Information System (WTIS), which currently captures wait times for surgery and diagnostic imaging in Ontario, will be expanded to capture ALC wait times. A key first step in the capture of high quality and near-real time ALC data is to ensure all clinicians are designating patients as ALC consistently in all acute and post-acute hospitals.

On behalf of the Ontario Ministry of Health and Long-Term Care and eHealth Ontario, the Wait Time Information Program (WTIP) at Cancer Care Ontario, worked in consultation with health care stakeholders from across the province to develop a standardized Provincial ALC Definition. The definition that was developed is applicable for all patient populations across the continuum of care, in both acute and post-acute hospitals, and is designed to be easily applied by clinicians. On July 1, 2009, all

hospitals in Ontario began using the standardized definition when designating patients as ALC.

Currently, the WTIP continues to support health care providers as they work to ensure the definition is applied consistently within their organizations. Also, the WTIP is in the process of planning activities to support the capture of ALC data. These activities will occur in a number of phases, with initial data being reported by the end of the calendar year. Soon, timely and accurate ALC data that is comparable at a provincial level will be available to support Ontario's continued efforts to improve patient flow, reduce emergency room wait times, and inform decisions regarding the allocation of resources to hospitals and communities.

As clinicians, we need to continue to support initiatives of this nature, as they will allow us to identify gaps in the health care system. In particular, audiologists and speech-language pathologists have an opportunity to shine a light on the need for access to hearing, communication, speech and swallowing services for all Ontarians along the continuum of care. By collecting this data, we will be in a much stronger position to advocate for the resources necessary to support our patients' communication and swallowing needs.

For a copy of Ontario's Provincial ALC Definition, please visit www.cancercare.on.ca/ocs/alc, or if you have any questions regarding this initiative, please email ALCdefinition@cancercare.on.ca.

The Age of the Electronic Health Record

By Karen Luker, Deputy Registrar

Where do we go from here

*Now that all of the files
have been thrown out?*

*And how do we spend our
time*

*If there's no one to lend us
a hand?*

Adapted from “Games People Play”

The Alan Parsons Project

The age of the electronic document has arrived. CASLPO has been flooded with calls and e-mails from members requesting advice on how to deal with the transfer of patient/client records to electronic media. The challenge this presents is two-fold: what to do with archived files that have been developed using traditional paper-and-pencil methods that are being converted to digital media, and what to do about new files that must be created using electronic means only. Audiologists and speech-language pathologists have also been engaged to participate in the development of software applications that will meet their employer's needs while complying with the requirements of regulations as set out by the College.

There are many uses associated with patient/client health records. Not only does the record document

patient care, but it also provides financial and legal information. It can be used for research and quality improvement purposes. Because much of this information must be shared among professionals within the healthcare team, and there continue to be problems with the paper health record, it is becoming more apparent that developing an automated health record is very important.

The electronic health record (EHR) provides the opportunity for health care organizations to improve quality of care and patient safety. It allows the health care system to provide comprehensive, reliable, relevant, accessible, and timely patient information to each member of the health care team. An EHR also represents a huge potential for cost savings and decreasing workplace inefficiencies. Increased storage capabilities alone account for much of its appeal. Some of the other advantages associated with the EHR include:

- The EHR may be set up to be accessible from remote sites to many people at the same time, and retrieval of the information is almost immediate. The record is continuously updated and is available concurrently for use everywhere;
- The EHR can instantly connect the clinician to protocols, care plans, critical paths, and databases of health care knowledge;
- It allows for customized views and reporting of information relevant to the needs of various specialties;
- It can provide information to improve risk management and assessment outcomes;
- It can decrease charting time and charting errors, therefore increasing the productivity of

health care workers and decreasing medical errors due to illegible notes;

- Chart chasing is eliminated, as is duplicate data entry of the same information on multiple forms. The patient is happier, because information is available so the patient does not have to continue to provide the same information over and over again.

Even though the technology is available, there are several barriers and obstacles that must be overcome before any EHR endeavour can be successful including organizational and human issues. Some of the disadvantages include start-up costs, which can be excessive. There is also a substantial learning curve and it is helpful if the users have some type of technical knowledge. Today, clinicians are the primary users of EHRs; systems must therefore be user friendly, otherwise they will not be easily accepted, nor will they be used to their fullest capacity.

One of the biggest challenges facing clinicians is the fact that they must adhere to their respective Colleges' legislative requirements, while dealing with EHR systems that do not necessarily make provisions for these. When clinicians are consulted in the development of EHR software, they are often overwhelmed by the number of considerations, questions, and factors which must be taken into account in order to ensure compliance and practical use.

Where Do We Go From Here?

The following discussion addresses some of the issues which have been brought forward to CASLPO by clinicians who are considering or are

involved with the transition to electronic health records.

Document Retention and Disposal: To Scan or Not to Scan?

Members who are involved in transferring records to an electronic format frequently ask what needs to be scanned and/or retained. The answer is the same as that for paper records. CASLPO's Proposed Regulation for Records (1996) indicates that:

5. (1) Subject to Sections 6 and 7, a member shall keep a patient or client record for each patient or client whom the member treats or assesses.
 - (2) The patient or client record must include the following:
 - a. The patient's or client's name and address and phone number;
 - b. The date of each of the patient's or client's visits with the member, unless this information is available from some other readily accessible source;
 - c. The name of the referring source;
 - d. Pertinent history of the patient or client or reference where this information may be found;
 - e. Reasonable information about assessments and treatments performed by the member and reasonable information about significant clinical findings, diagnosis and recommendations made by the member;
 - f. Reasonable information about significant recommendations made by the member for examinations, tests, consultations, or treatments to be

performed by any other person;

- g. Every written report received by the member with respect to examinations, test, consultations, or treatments performed by other professionals or a reference to where the reports are available;
- h. Reasonable information about advice given by the member and every pre-treatment or post-treatment instruction given by the member;
- i. Reasonable information about every controlled act within the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991, performed by the member;
- j. Reasonable information about every delegation of a controlled act within the meaning of Subsection 27(2) of the Regulated Health Professions Act 1991, by the member including the name of the person to whom the act was delegated;
- k. Reasonable information about every referral of the patient or client by the member to another professional;
- l. Any reasons a patient or client may give for cancelling an appointment;
- m. Reasonable information about every *relevant and material service activity* that was commenced but not completed, including reasons for the non-completion;
- n. A copy of every written consent related to the member's service to the patient or client.

It should be noted that at present,

CASLPO does not provide a definition of "reasonable information." It is up to the individual clinician and/or employer to determine what information is considered reasonable.

Confidentiality and Security: Going into Hiding

Confidentiality and security issues are concerns associated with both the paper health record and the EHR. There has been much discussion about this topic and although the patient record must be protected, the patient must also remember that the record has to be accessible to the professionals who use the records to provide medical care. There are several security technologies available that will help prevent unauthorized access to protected health information. Some of these technologies include firewalls and passwords. Furthermore, properly designed and monitored audit trails can enhance user accountability by detecting and recording unauthorized access to confidential information. System designs must consider how individually identifiable medical information will be protected and also meet CASLPO's regulatory requirements, which include the following:

- (3) Where a member makes or keeps records required by this regulation in an electronic computer system, the system shall have the following characteristics:
 - f. The system includes a password or otherwise provides reasonable protection against unauthorized access.
 - g. the system backs up files and allows the recovery of backed up files or otherwise provides reasonable protection against loss of, damage to, and inaccessibility of, information.

Most systems will provide a means to ensure that the author of every entry is identifiable through some type of unique identifier or password protection.

Portability and Access to Equipment: Does the Computer fit into the Trunk of My Car?

Placement of hardware is an issue and decisions regarding the portability of equipment and remote access to files must also be considered. CASLPO suggests that clinicians carry and access information only when necessary and that only necessary information be carried and accessed. All digital information should be encrypted and protected. This would not preclude the clinician's ability to access patient/client files remotely; however, safeguards must be built into the process. Should a breach occur, the provisions of the Personal Health Information Protection Act (2004) apply (see CASLPO's "PHIPA Guide: Privacy Requirements and Policies for Health Practitioners", available on www.caslpo.com).

Organizing the Information: Storage Solutions

There are probably as many methods of storing records as there are records themselves. CASLPO members are reminded that any electronic record-keeping system must ensure their compliance with the following sections of the Proposed Regulation for Records (1996):

- (3) Where a member makes or keeps records required by this regulation in an electronic computer system, the system shall have the following characteristics:
 - a. the system provides a visual display of the recorded information;

- b. relative to the patient or client record(s) and financial record(s), the system provides a means of access to the record of each patient or client by the patient's or client's name;
- c. the system is capable of printing the recorded information without unreasonable delay;
- d. relative to the patient or client record(s) and financial records(s), the system is capable of visually displaying and printing the recorded information for each patient or client in chronological order;

Preparation of Documents: Draft Dodgers

Speech-language pathologists have expressed apprehension over the fact that draft progress notes and reports which are entered into electronic charting systems automatically become part of the official record (and are therefore accessible to whoever else has access to the record) as soon as the "Enter" button is depressed on the keyboard. Furthermore, clinicians indicate that using "cut and paste" functions available through word processing software are disallowed in their employer's electronic record-keeping system. One way to avoid this is to ensure that clinicians are involved in the design of the system from the outset. Ensuring that software developers and consultants are aware of professionals' needs is the best way to have specific needs addressed and system limitations avoided.

Modifications and Corrections: Oops!

Clinicians are concerned with their ability to modify information or make corrections once an entry has been made. One of the advantages

of electronic record-keeping is that most systems have built-in audit trails, which ensure that all entries are tracked by author, date, and time. This becomes a challenge in the case where incorrect information has been entered, or where a clinician may wish to review and modify the information entered by a student or support personnel. As with the issue of draft documents, the most efficient method of dealing with this situation is to be involved in the design of the system from the outset. Should this not be feasible, clinicians must be mindful of the requirements of the Proposed Regulation for Records (1996):

- (3) Where a member makes or keeps records required by this regulation in an electronic computer system, the system shall have the following characteristics:

- e. the system maintains an audit trail that:
 - (i) indicates any changes in the recorded information;
 - (ii) preserves the original content of the recorded information when changed;
 - (iii) in respect to the patient or client record and financial record of each patient or client;
 - A. records the date of each entry of information for each patient or client; and
 - B. is capable of being printed separately from the recorded information for each patient or client.

- 9. (1) Where in this regulation a notation, report, record, order, entry, signature or transcription is required to be entered, prepared, made, written, kept or copied, the entering, preparing, making, writing, keeping or

copying may be done by such electronic or optical means or combination thereof.

- (2) A member shall ensure that the electronic or optical means referred to in subsection (1) is so designed and operated that the notations, report, record, order, entry, signature or transcription is secure from loss, tampering, interference or unauthorized use or access.

Titles, Designations, and Signatures: Where Does It All Go?

Members report that some electronic charting systems provide only a minimal amount of space – or a set number of characters – in which to enter their name and designation(s). One solution is to enter an abbreviation which designates the professional (e.g., Juliette Fisher, SLP), and to develop an accompanying policy that indicates the full title to which the abbreviation refers. Another is to have the space extended by the programmer so that full names and designations may be entered.

Original signatures are not necessarily accessible in EHRs, so how are members to indicate that they have authored a report or note? As mentioned above, most systems account for this by tracking the author of every single entry, and only certain portions of the record may be accessible to individual practitioners. Ideally, the software should clearly indicate the author of the entry during printing as well.

Where Do We Go From Here?

The electronic health record provides a new and innovative information management tool which contributes to integrated

care, evidence-based practice, computer-based decision support, care planning, and analysis of outcomes. Although the benefits are clear, there are still barriers; therefore the concept is still not widely accepted. There are many factors which must be considered before an organization implements electronic health records, and the involvement of

end-users from the early stages of development will help to ensure its success.

CASLPO will be developing documentation related to the issue of electronic documentation in the next several months. Members are encouraged to submit their questions and challenges to Karen Luker at kluker@caslpo.com for consider-

ation during the development

phase.

Taking Leave from the Practice of Audiology or Speech-Language Pathology

By Colleen Myrie, Manager of Registration and Karen Luker, Deputy Registrar

The act of departing one's work setting for a short or extended leave carries with it a number of responsibilities and questions.

Taking leave can be the result of careful planning and preparation, such as with a pregnancy, an educational pursuit, or a well-deserved sabbatical. It can also be the unfortunate outcome of difficult circumstances such as illness.

Preparing for Leave

Every year, many members face the daunting task of getting everything ready prior to taking leave. This involves ensuring that reports are complete and that client charts are in order. It may also include training a replacement or distributing outstanding and ongoing responsibilities to colleagues. Members must also consider their status with the College for the duration of their absence.

CASLPO is aware of the challenges facing our members during short or extended periods of leave. Depending on the length of the

leave and the desire of the member to practice during that period our members have four options:

1. Retain "General" membership. This option would be useful for members who plan to take a leave from full time practice but still wish to practice part time while on their leave or wish to take a leave of less than one year.
2. Become a "Non-practicing" member. The "Non-Practicing" class of membership is available to members who will not be practicing at all during their leave, but intend to return to work and general membership at the end of their leave. The annual fees for "Non-Practicing Members" are \$250.00 per year.
3. Become a "Life Member." This class of membership is for those members who do not anticipate coming back to work in the

future but wish to maintain their ties with the profession. The annual fees are \$50.00 per year.

4. Resign their membership. This would be for those members who decide that they will no longer practise as an audiologist or speech-language pathologist in Ontario.

Each of these options is described below.

Maintaining General Member Status

General members have the ability to leave their practice for an extended period (e.g., for a maternity leave), as long as they complete 250 hours of patient care or related work annually, or 500 over two years. This requirement applies regardless of the type and duration of leave. Assuming a member takes

four weeks vacation in one calendar year, 250 hours represents approximately 5.2 hours per week. Keeping in mind that the hours may be comprised of both patient care *and* related work, this could easily correspond to just a few clients. However, if a member who holds a General certificate of registration fails to provide 500 hours of patient care or related work within the last two years of professional practice, the member must be reviewed by the College's Registration Committee.

Members do not need to advise the College of their absence from practice if they anticipate meeting the hourly requirements. In making final preparations, however, members should ensure that their Self-Assessment Tool is up-to-date and accessible.

To maintain General membership status, certain requirements continue to apply despite a member's absence from practice:

Annual Renewal: Members must continue to submit their annual renewal form (or complete this online). Membership fees of \$500.00 must be paid in full.

Continuous Learning Activity Credits (CLACs): Members may accumulate CLACs during the period of leave. This is not mandatory, but the minimum number of 45 credits must still be obtained over the three-year cycle.

Self-Assessment: Members are expected to continue to complete their Self-Assessment Tool (SAT). As the selection of members who must submit their SAT is generated by an off-site computer in order to ensure they are truly randomized, any General member can be selected while on leave.

Peer Assessment: From the pool of SATs submitted, 30 members are

randomly selected to participate in the peer assessment process. Members who are selected while on leave may contact the College to request a temporary deferral of the process.

Becoming a Non-Practicing Member

The "Non-Practicing" class of membership is available to members who will not be practicing at all during their leave, but who intend to return to work and re-establish their General membership at the end of their leave. The annual fee for Non-Practicing Members is \$250.00 per year.

This class of membership was specifically created to enable members to take a leave without worrying about whether or not they will be allowed to return to practice without additional requirements. It also removes the need to submit self-assessment tools or to be peer assessed for the duration of the leave.

To become Non-Practising, the member must submit a renewal form with the change of class request section completed. This should be done prior to the October 1st deadline for registration renewals. There is no application fee for members who apply to become non-practising at renewal and a General member's fees will be reduced from \$500.00 to \$250.00 as a non-practising member effective October 1st. If however, a member applies to become non-practising at any other time during the membership year which runs from October 1 to September 30, there will be an application fee and no reduction in fees until the following October 1st.

Members who are non-practicing must apply to the College annually

to maintain their non-practicing status. They *may* fulfill any continuing education requirements expected of holders of a general certificate of registration during absence from practice, but *must* do so before applying for reinstatement as a General member. There are no additional requirements to be met if leave is shorter than three years, however, re-entry to practice does involve contacting the College first to apply for a General certificate of registration.

Generally speaking, if a member has been away from practice for more than three years, his or her application will be referred to the Registration Committee for consideration. The committee may elect to impose re-entry requirements such as asking the member to undergo a supervised practice period in order to give the member an opportunity to "refresh" his or her knowledge and skills.

If a member holding a Non-Practicing certificate of registration for a period of five years or more applies for a General certificate of registration, the applicant must be reviewed by the Registration Committee and may be required to successfully complete a period of mentorship and an examination specified by the committee.

Applying for Life Membership

The College offers a Life certificate of registration to individuals who have retired from the practice of speech-language pathology or audiology due to age, disability or other personal reasons, but who wish to retain their membership with the College.

Life (retired) members are restricted to the use of the following titles:

Speech-Language Pathologist –

Retired;

Speech Therapist – Retired; or

Audiologist – Retired.

Life (retired) membership is for members wishing to retire permanently. Should circumstances change, life (retired) members wishing to return to practice must make a full application for general membership. This will include submitting a new application to the College along with official transcripts, a summary of university supervised clinical practicum hours, and applicable fees. In order to become reinstated as a general member, the life (retired) member must meet the current registration requirements and may be subject to any terms, conditions and limitations which the Registration Committee considers appropriate.

Resigning from Practice

If a member decides that they will no longer practise as an audiologist or speech-language pathologist in Ontario, the member may choose to resign from the College. In order to resign, the member must send a resignation letter to the College or notify the College of his or her resignation on the annual registration renewal application form. When the resignation becomes effective, the member's Certificate of Registration expires and they must cease practising in Ontario.

If a former member of CASLPO applies for a General certificate of registration and it has been more than three years since the applicant held a General certificate of registration, the applicant will be subject to the regulations and procedures in force at that time. The applicant must submit a new application, along with verification of the applicant's registration, licen-

sure or certification in another province, state or country, a reference from the applicant's most recent employer in another jurisdiction, proof of professional liability insurance coverage and payment of all applicable fees.

If a former member of CASLPO who has been absent from professional practice for a period of more than three years, applies for a General certificate of registration, the applicant must be reviewed by the Registration Committee and may be required to successfully complete a period of mentorship specified by the Committee and/or successfully complete an examination specified by the Committee.

How Do CASLPO Requirements Compare to Other Colleges?

On occasion, members have com-

mented on the reasonableness of the College's requirements, with respect to patients hours, especially as they apply to individuals who choose to work "very part-time" or who wish to take an extended leave.

In other words, when does a Speech-Language Pathologist or Audiologist forget how to be a Speech-Language Pathologist or Audiologist?

The College's mandate is to regulate the professions in the public interest. The College must devise programs which assure consumers they are receiving quality services from competent professionals. The requirements have been set as a means of providing this assurance, and of offering members support as they re-enter the workforce.

A brief survey of other Regulated Health Professions in Ontario reveals that CASLPO's annual hourly requirements are consistent with:

Profession	1 Year*	2 Years	3 Years	5 Years
SLP and Audiology	250	500		
Physiotherapy	(240)			1,200
Occupational Therapy	(250)		750	1,550
Nursing	(225)			1,125
Pharmacy	(200)		600**	

*Numbers in brackets are extrapolated from the 3 and 5-year requirements

**Must be direct patient care

CASLPO is reviewing its requirements regarding leave. Should you have any questions, comments, or suggestions regarding leave, please do not hesitate to contact Colleen Myrie, Manager of Registration, at 1-800-993-9459, ext. 211 or Karen Luker, Deputy Registrar, ext. 226.

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 CASLPO 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 health care 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 license 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.”

Registration Renewal 2009/10

Once again this year, you will be able to complete your registration renewal online. Last year, 76% of CASLPO’s members completed their annual registration renewal online.

The deadline for renewal this year is **Thursday, October 1, 2009**. Your renewal forms and fees must be received at the College office by mail or completed online on or before October 1. Renewals received after October 1 will incur a 20% late penalty.

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. 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.

You will notice that this year’s form is longer than in the past. The Ministry of Health and Long-Term Care and CASLPO are working together to learn more about our profession by collecting demographic, geographic, educational, and employment information. This data collection is part of HealthForceOntario, the province’s health human resources strategy. Your answers to these questions will help the ministry develop policies and programs that address supply and distribution, education, recruitment and retention for your profession.

All of Ontario’s 80,000 regulated allied health professionals are providing this information as part of their annual registration and renewal process. To protect your privacy, the data we submit to the ministry will be made anonymous. You are required to provide this information under the *Regulated Health Professions Act, 1991*.

The reliability of the information we receive and the quality of the decision-making that follows depends on you. By completing your renewal form accurately and thoroughly, you will help ensure that Ontarians have access to the services of your profession, when and where they need them.

Additional information regarding HealthForceOntario and the required information may be obtained at: **www.healthforceontario.ca/WhatIsHFO/evidence_hhr/hpdb.aspx**.

NOT RENEWING

Members who decide not to renew their certificate of registration for 2009–2010 must 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.

Advocating for Ontario's Speech-Language Pathologists and Audiologists

By Mary Cook, Executive Director, OSLA

The Ontario Association of Speech-Language Pathologists and Audiologists is well-positioned to represent the professions at the provincial table where issues of interest are decided. As an association, we are invited to meet with the Ministries of Health and Long-Term Care, Education, Child and Youth Services, Finance, and Community and Social Services. We work hard to build positive relationships with ministry staff so that our services are respected and valued and so that we continue to be included in meetings where funding and service delivery issues are decided.

2009 – 2010 will be an exciting and challenging time for OSLA and its members. Here are some highlights of our upcoming activities representing SLPs and Audiologists in Ontario:

- Participation in the joint ministry review of the CCAC School Health Support Services Programme which will determine how these services should be funded and coordinated;
- Lobbying for improved funding and standards for service delivery for audiology services for children age 18;
- Consultations with the Financial Services Commission of Ontario (FSCO) will result in our suggestions included in the official recommendations of

their five-year review of auto insurance;

- Rollout to all Ontario School Boards of the *Oral Language Foundations for Academic Success*, a major education document researched and written by OSLA members;
- Chairing and leading the initiative for CASLPA's Wait List Times for Non-Progressive Neurological Disorders;
- Participation on the Collaborative Rehabilitation Group of Ontario College/University Programs for Rehabilitation Sciences (OCUPRS);
- Allied Health Professional Development Fund (AHPDF) allowing OSLA members the possibility of accessing up to \$1,500 for professional development per annum;
- Providing a voice for members at the Workplace Safety and Insurance Board (WSIB) on issues relating to the Noise-Induced Hearing Loss and Mild Traumatic Brain Injury Programs of Care as well as the Revised Fee Schedule review;
- Fall 2010 – A Joint Conference with CASLPO!

OSLA continues to be concerned about ongoing issues of insufficient funding or poor service delivery models for our professions as well

as new issues as they arise – for example, the impact on the provincial blended sales tax (HST) and how it will affect the delivery of services by audiologists. We need OSLA at the table!! And enjoy peace of mind knowing that you are a member of the organization that speaks for you on matters that affect your practice and your profession. We hope you are excited as we are about the events and challenges impacting our vibrant professions.

In addition to our many advocacy efforts, OSLA continues to be a resource for our members. We provide support and seek member input through our committees, regional chapters and interest groups. Our members also have online access to resources such as discussion forums, the member directory, pertinent documents, surveys, and data and information relevant to your practice in Ontario written specifically by and for speech-language pathologists and audiologists including OSLA's *Suggested Fee Schedules*.

We know that OSLA members are a dedicated group of professionals who value the strength of a resource-rich association; you recognize that a strong voice in Ontario is necessary for you as a speech-language pathologist or audiologist practicing in this province. OSLA is here to support you; you have a team of peers and support staff available to you. OSLA is here to help!

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1 Yr contract : July 2009 – July 2010

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Regional Support Associates offers a range of education and training activities and a competitive compensation package.

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293 Wellington Street North, Woodstock, Ontario N4S 6S4

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We thank all applicants but only those chosen for an interview will be contacted.

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A stylized map of Canada is shown in the background. The landmasses are green, and the water bodies are light blue. Overlaid on the map are numerous silhouettes of people in various poses, some walking, some standing, and some carrying bags, representing a diverse group of individuals across the country. The word 'CANADA' is written in large, light green, semi-transparent letters across the middle of the map.

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Together We're Stronger

Unforgettable

By Sherry Hinman

The first day Rose* clunked her walker into my office at Lakeridge Health, where I worked as a speech-language pathologist, I was taken by the sweet, 92-year-old's smile. Rose's speech was a little slurred from her stroke, but she could fully express herself, and her Jamaican upbringing wove its way through her island accent.

We worked together, initially on her dysarthria, but the focus of therapy soon shifted to compensating for the cognitive problems that developed as she began to have stroke after stroke. In a matter of months, this delightful woman lost all connection with those around her.

Thoughts of Rose fell to the back of my mind after she was transferred to the long-term care unit, and I never expected to see her again. But one day, I passed her in the hall, slipped feet shuffling her wheelchair forward with slow tiptoe movements, her eyes staring vacantly ahead.

Forgetting the devastation the strokes had caused, I crouched down to bring my face level with hers, and touched her arm. "Rose! Do you remember me? It's Sherry!" No glimmer of recognition; no response. Hope spun away as I realized what the strokes had stolen from her.

And then I remembered something that used to reach Rose in therapy, and I began to sing. "Amazing Grace..." As if in a reflexive response, Rose's jaw dropped and a loud, throaty voice joined mine.

"...how sweet the sound..." came our two voices. "...that saved a wretch like me..." As we sang, a



Sherry Hinman

hand appeared on Rose's shoulder and a third voice joined in. Our music swelled as three of the nurses added their voices. As I looked up, I saw that all the nurses at the nursing station had dropped their paperwork to watch, and several had begun to sing.

As the verse came to a close, Rose's jaw, too, snapped closed and her face resumed its stare. As I straightened up, I saw the faces of the nurses around me, some wet with tears.

"Have you never heard her sing?" I asked them.

"No," one nurse answered. "Rose has been here for a couple of years. And in all that time she's never spoken before. I didn't know she could."

"Sing to her," I said. "Sing to her whenever you can. It's all that's left



Janice Krymuza

of her."

As clinicians, we all meet people who leave their mark on us in indelible ink and make us richer for the experience. We spoke to a few other speech-language pathologists and audiologists and asked them for their stories about those who have affected them unforgettably in their clinical lives.

Janice Krymuza is a speech-language pathologist who encountered three-year-old Cody and his family when she was working with children privately in her clinic,

Working with Words, in Stittsville. Her assessment revealed that Cody had a severe expressive and receptive language delay as well as difficulties with social and play skills. "The family was grief-stricken," Janice recalls. "They just didn't know how to get him to talk."

Janice had her work cut out for her. "Cody didn't have pretend play," she says. "So we modelled pretend play. A few weeks later his mom reported that he began driving his toy cars, sitting on a mat, which brought her to tears."

Being able to work with the young boy and his mother in their own home was key, Janice recalls. "By having motivated parents on board and right there participating means the amount of progress was a lot faster and more evident." Within a few months, Cody's expressive language flourished, soon reaching within normal limits. Though his receptive language progressed significantly as well, it remained a concern and he was eventually diagnosed with PDD/NOS (pervasive developmental disorder/not otherwise specified).

Janice gained a great deal of satisfaction from working with Cody and his family. "It was not 'cookie cutter' therapy," she says. "It was a question of putting the pieces of the puzzle together. It was about treating the family as a unit." Janice worked with Cody and trained his mother, helping her learn techniques. "Whatever I recommended her to do, she did."

When she reflects on what she learned from her encounter with this young boy and his family, Janice says, "I felt like all I had learned came together. Knowledge of multiple techniques and approaches as well as hands-on experience are important, and these matter more than textbooks."



Yvonne Oliveira

She adds that her great sense of satisfaction came from pulling all her experiences together. "You need to have the knowledge base, but with experience you are able to know what is needed for each child and family. This can result in wonderful success." She adds, "Plus being a parent myself has affected my approach with families."

When Yvonne Oliveira describes the "beautiful, bright little girl" who came into her office at almost four years of age, you can sense the connection instantly. Yvonne is a speech-language pathologist, audiologist and auditory-verbal therapist who runs her own clinic, HearSay Speech & Hearing Centre, in Milton.

Mariana's hearing loss was identified late, but she had already been wearing her hearing aids for 15 months by the time she came to see Yvonne for aural rehabilitation therapy. Mariana's parents were concerned with the lack of progress in her speech and language development, and wanted to build her listening skills through the use of her hearing aids. Unfortunately she

had been denied candidacy for a cochlear implant, though that remained a hope for the future.

At the time Yvonne began to work with Mariana, she had only a handful of single words, and was not consistently localizing to sound. One of her few words was /a-i/, the word she used to call her mom.

Without fail, Mariana's family would attend hour-long rehab sessions, but despite their dedication, it soon became evident that Mariana lacked access to the entire speech spectrum, always struggling to detect the /s/ and other high frequency sounds. Unfortunately, however, she was wearing the most powerful behind-the-ear hearing aids available.

But through diligent weekly sessions, Mariana made enough progress to be considered eligible for a cochlear implant. Yvonne recalls the day both she and the family rejoiced at this news, much as she will never forget the day Mariana's implant was first activated. "When her mother described Mariana's excitement and positive reaction to the sounds she heard when the implant was turned on, I couldn't help but cry tears of joy for all of them. This began a new chapter in Mariana's life!"

Yvonne says there was no end to the thanks and praise the family bestowed upon her, yet she feels it was their positive attitude, loving nature, and patience for their child that made the biggest difference. "They became not just a client, but a friend, and an extension of my own family."

Corina Murphy will never forget speaking to the parents of 14-year-old Katie, following her assessment. "I looked down at my folded hands, sighed deeply and looked up into their expectant faces. 'Katie is displaying neurological symptoms,' I

told them.” The parents were in disbelief.

When she asked Katie to yell as loud as she could, she barely whispered. *How would she be able to yell and laugh with her girlfriends or shout at a football game?* Corina wondered. When she asked Katie to smile and pucker, she could perform neither movement. *How would she smile at her prom or kiss that boy she had a monster crush on?* The list of symptoms went on: poor breath support, hypernasal resonance, imprecise velar consonants, absent soft palate movement, inability to swallow meats, and inability to use a straw to sip drinks. With each observation, the alarm bells in Corina’s head

Corina Murphy

rang louder and the knot in her stomach grew tighter.

They tried to guess at the cause of Katie’s problems, but nothing added up: her new braces, Bell’s palsy, a brain injury or, worse – a brain tumour? All Corina could think about was that Katie might not make it to her high school prom.

Katie was scheduled for an urgent MRI, and a week later, Katie’s father called to say she had been diagnosed with myasthenia gravis, exacerbated by the anesthetic for her tooth extractions. Corina sighed with relief, knowing that myasthenia gravis was treatable. For months afterward she received weekly updates from Katie’s parents; her illness had not responded well to drugs, but surgery to remove her thymus gland had restored most of her speech.

Corina recalls with fondness a visit from Katie a few months after her

surgery. Katie brought her a teddy bear puppet to use in her private practice. “As they left, Katie smiled. At that moment, I could see the Katie of a few years in the future: the chubbiness of pubescence gone from her face, her teeth straight and clear of braces, all decked out in her prom dress.”

As for the bear – now tattered and one-eyed after dozens of encounters with preschoolers and Corina’s dog and son – it sits in a place of honour on her shelf, a reminder of the effect she had on one child, one family.

Sherry Hinman is a freelance writer and editor. She is also a professor in the Communicative Disorders Assistant Program, Durham College; worked clinically as an SLP for fourteen years; and served three years on the CASLPO Council

Names of patients/clients and a few personal details have been changed to preserve their privacy.



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