

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

THE ONTARIO ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS (OAMRT)

The OAMRT is a voluntary association representing approximately 4,000 Members.

The OAMRT is the official voice for the profession of Medical Radiation Technology in the Province of Ontario. As such, the Association is the advocate for Medical Radiation Technologists (MRTs) representing their needs and their views to the government and other stakeholders.

The OAMRT was founded in 1935 as an independent, non profit organization. During this time, it has been responsible for a number of initiatives that have shaped and helped to shape health care in Ontario. The Association has been a driving force concerning the evolution of Medical Radiation Technology in Canada and will continue to be as a key partner and stakeholder in the Ontario health care system.

The OAMRT believes in the principles of collaboration and partnership to ensure an effective, efficient and safe health care environment.

The OAMRT is governed by nine Board of Directors with a representative from the national association sitting on the Board. It has representation from all areas of the province through it's regional or "Section" system. In this way communications flow from the grass roots up and from the decision makers down and laterally to the various volunteers and leaders of the Association.

Although the Association's mandate is to provide leadership advocacy and education on behalf of its Members and to represent their needs, the safety and interests of the public are of primary concern to the Association in meeting its Mission and Vision.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

EXECUTIVE SUMMARY

The Ontario Association of Medical Radiation Technologists (OAMRT) believes that by expanding the controlled acts authorized to Medical Radiation Technology to be performed in the profession's own authority, in association with a diagnostic or therapeutic use of ionizing radiation serves the public interest and better protects them.

The entire health care system is under great pressure to provide quality and safe services in the least amount of time for the least amount of money.

This pressure is passed on to the Medical Radiation Technologist (MRT). The MRT has been asked in the past, and continues to be challenged, to take on more demanding tasks. This allows other members of the health care team, physicians in particular, to concentrate on the higher risk of more complex procedures.

The trend to shift duties and responsibilities will continue as health care delivery changes. The Medical Radiation Technology profession is in a state of rapid evolution here in Ontario as well as around the world.

The evolution, or what some might call a revolution, depending on your viewpoint, is not unique to Ontario. Nationally and internationally, the Scope of Practice for MRTs is changing. This is particularly the case in the United Kingdom, Australia and New Zealand, where MRTs are performing upper and lower gastric studies, diagnosing radiographs of upper and lower extremities, mammograms and more. The United States is also in a positive evolutionary phase concerning medical radiation practice. Due to these changes, expansion of the MRT scope of practice is inevitable.

The request to authorize, under the Medical Radiation Technology Act (MRTA), the three procedures or controlled acts is envisioned as a first step in the expansion of the MRT's scope of practice.

The OAMRT believes that the request for change:

1. Meets the spirit of the RHPA
2. Provides the public with choice concerning access to services
3. Protects the public
4. Legitimizes what the profession already does
5. Provides economies of scale
6. Confirms the trust physicians have already placed on MRTs
7. Mirrors standards of practice of the profession nationally and internationally
8. Recognizes the education foundation and potential of MRTs
9. Is within the envelope of the Scope of Practice Statement.
10. Allows for future changes to the profession.

All of which are important criteria.

The following competencies **putting an instrument, hand or finger beyond the labia majora and beyond the larynx** are procedures conducted by Radiation Therapists and are part of the Radiation Therapist's basic clinical training.

A third competency is **putting an instrument, hand or finger beyond the opening of the urethra**. All three competencies have long been established within the MRT's Scope of Practice. Although not part of the undergraduate curriculum, evidence has shown that this competency can be easily taught, tested and put into successful practice because of the academic and clinical practice foundation the MRT has already.

The Association believes that authorization of the three (3) controlled acts will be prudent due to the request for the inclusion of medical sonographers and MRI technologists to be regulated under the RHPA and members of the College of Medical Radiation Technologists of Ontario (CMRTO). It would be in the interest of the public to have these three controlled acts authorized to the CMRTO should these two occupations be regulated. Medical sonographers will require authorization of Controlled Act 6 v as it is integral to their practice. MRI technologists, by virtue of the nature of their practice with special magnetic coils, are now doing the types of procedure that will require such authorization. From a patient safety and economic point of view, having the proposed authorized controlled acts in place for the potential inclusion of medical sonography and MRI, makes common sense to the OAMRT.

Authorization of Controlled Acts 6 iii, iv and v is, in our view, futuristic and also ensures consistency in the performance of the described procedures across Ontario by the development, implementation and enforcement of the competencies through the agency that controls the practice of Medical Radiation Technology, The College of Medical Radiation Technologists of Ontario. This request will assist the Minister of Health in meeting her duty concerning the RHPA.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

INTRODUCTION

The Regulated Health Professions Act (RHPA) was introduced as “living legislation” to regulate and coordinate health professions in the public interest. Further, its purpose was to ensure that: (1) appropriate standards of practice are put into place and maintained; (2) patients are treated with sensitivity and respect; (3) there is a choice for the public in accessing services.

As “living legislation”, the expectation of our profession was and still is, that changes could be made when the evolution of technology and practice make the present practice boundaries impractical or obsolete. The RHPA then is unique in providing the vehicle to accommodate evolution of practice.

RHPA certainly brought about major reform in Ontario’s health care system and impacted on the socio-economic aspects of our society.

In reforming health care, the RHPA introduced the Scope of Practice/Controlled Act Model for health care professionals. No such similar legislation exists for other health care providers. The RHPA model then is based on responsibility and accountability.

In view of the Ontario Association of Medical Radiation Technologists (OAMRT), the essence of practice under RHPA consists basically of:

- Scope of Practice Statement
- Controlled Act Provisions
- The concept of Authorized Acts.

The Scope of Practice Statement has a different value depending on the health care profession involved. The term is not defined in the RHPA nor the individual profession specific acts. The OAMRT sees the Scope of Practice Statement as a general statement establishing the boundaries for the profession’s practice by implying both extent and limitations. As such, it sets the platform for what controlled acts the profession can perform in providing health care services.

Although there are many acts of providing health care, thirteen (13) were selected as the controlled acts that pose a risk of harm if performed by an unqualified, unauthorized person(s).

Under RHPA, the controlled acts are “authorized” to a health profession. That authorization is based on the professions’ scope of practice statement under the profession specific act, which in the case of the OAMRT is, the Medical Radiation Technology Act (MRTA).

The “Authorized Act” is understood as a controlled act procedure authorized to a profession to perform, either in full or in part, depending on the Scope of Practice and the defined competencies. These “acts” can authorize professionals, such as Medical Radiation Technologists (MRTs), to perform procedures outright without any conditions. Other practitioners may have additional requirements that must be met prior to implementation, such as the requirement to have an order from another profession.

The OAMRT has supported the College of Medical Radiation Technologists (CMRTO) with their policy that MRTs cannot delegate procedures at this time. Accepting delegation of controlled acts has been supported by this Association.

The OAMRT believes that in keeping with the evolution of their profession that those areas of practice delivered by an MRT that are controlled acts should be authorized to rather than delegated to MRTs.

The OAMRT is pleased to respond to the Minister of Health's referral as stated below:

In using ionizing radiation for diagnostic and therapeutic purposes, medical radiation technologists perform controlled acts, specifically: putting an instrument, hand or finger beyond the labia majora (for placing vaginal markers); beyond the opening of the urethra (for urinary catheterization), and beyond the larynx (to maintain airways during treatment). Currently, these acts are performed under delegation.

Please provide advice on whether there is a need to better protect the public by expanding the controlled acts authorized to medical radiation technology to allow these procedures to be performed on the profession's own authority in association with a diagnostic or therapeutic use of ionizing radiation, in order to remove the requirement for delegation.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

THE EVOLUTION

Medical Radiation Technology is evolving rapidly due to changes in technology, medical practice and the accelerated advances in medicine.

Nationally, there is an awareness that the challenges to the profession, of providing the services to other health care providers and the public need to be met. Included in the national practice environment is the inclusion of Magnetic Resonance Imaging (MRI) and the recognition and acceptance of diagnostic sonography as professional diagnostic practices. The MRTA's scope of practice allows for these two areas of diagnostic imaging in Ontario.

Legislation needs to be flexible and accommodating, while still providing the necessary safeguards to society. If it isn't, many stressors will be placed on an already burdened health care system. This can be avoided. Ontario is unique in having the RHPA as "living legislation" and leads the way in terms of having the legislative structure to respond to or accommodate change. The MRTA's Scope of Practice statement is an example of a provision which allows change to be accommodated. Change is what the Medical Radiation Technology profession faces. Internationally MRTs are providing health care services in areas Ontario MRTs are just exploring.^{1,2}

In the United Kingdom, Australia and New Zealand, advanced practice is a reality. MRTs are doing upper and lower gastrointestinal (GI) studies,³ reporting of plain films,⁴ reporting mammograms, providing direct patient care through radiation therapists and bone densitometry interpretation by nuclear medicine technologists.

Similar initiatives to those in the United Kingdom are underway in the United States.

Nationally, the OAMRT started the advance practice process through launching of the discussion paper the *"Initiatives for the Millennium."* The Ordre des Technologies en Radiologie du Quebec (OTRQ) have built on this initiative and are making considerable progress in the area of advance

¹ College of Radiographers, 1996, Continuing professional development strategy (final report of working party)

² College of Radiographers, 1996, Continuing professional development, Facing the future together: The challenge of life long learning.

³ College of Radiographers, 1998, An Investigation of Radiographer performing barium enemas

⁴ Canterbury Christ Church College, 1996, Page C, radiography (clinical reporting) appendicular and axial skeleton

practice for MRTs.⁵

On the global scene, the International Society of Radiographers and Radiological Technologists (ISRRT) have hosted a number of conferences where advance practice is on the agenda. Items such as interpretation of images, performance of examinations of the Digestive System by MRTs, clinical breast examination and other areas of practice are being included in scopes of practice and where MRI, lithotripsy, thermography and ultrasound are considered the domain of medical radiation practice.

In Canada, the national association, the Canadian Association of Medical Radiation Technologists (CAMRT) has worked with the CMRTO, cognizant of the CMRTO's mandate. This partnership has resulted in:

- Agreement on undergraduate training program competencies
- Entry into practice requirements
- Recognition of the CMRTO's Standards of Practice (SoP)
- The monitoring of the evolution of practice.

Medical radiation practice in Ontario will evolve, without any reservations, to mirror what is happening in the UK, our sister association in Quebec and other international jurisdictions. MRI as a part of professional practice is a reality. MRTs doing multi-disciplinary work in medical sonography is a reality. The elevation of our scope of practice envelope is inevitable, and is presently being pushed.

⁵ OTRQ 1999, Radiological Technologist a Profession for the future: consultation Paper

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

MRT SCOPE OF PRACTICE

The Scope of Practice Statement for MRTs states as follows:

“The practice of medical radiation technology is the use of ionizing radiation and other forms of energy prescribed under subsection 12(2) to produce diagnostic images and tests, the evaluation of the technical sufficiency of the images and tests, and the therapeutic application of ionizing radiation”.

Although the Scope of Practice Statement is broad in one sense, it does reflect what MRTs do concerning ionizing radiation. It also provides for the inclusion of those modalities that produce other forms of energy such as diagnostic ultrasound units, MRI, lithotriptors and other energy emitting and receiving devices.

The inclusion of the term “*and other forms of energy*” was deliberate during the formation of the RHPA. This Association, the then Board of Radiological Technicians (BRTO) and the Ontario Association of Radiology Managers (OARM) foresaw the day when practice requirements and responsibilities would change.

The scope of practice to us, provides the foundation and serves as a tool to allow and to accommodate the inevitable evolution of practice. The request before the Council is part of that evolutionary process.

It is important then, from our perspective, that the scope of practice accommodates not only what the profession does and the practice methodology used, but what MRTs are being asked and pressured to do by the gatekeepers of the health care system.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

AUTHORIZED ACTS

The RHPA by its virtual design allows the situation where elements of practice overlap. This is certainly the case between MRTs and other health care professions and occupations.

The situation of “overlap” is at times confusing to all those who are health care providers.

Here in Ontario, where MRTs are governed under the RHPA, MRTs are currently authorized to perform four (4) Authorized Acts - they being:

- Taking blood samples from veins;
- Administering substances by injection or inhalation;
- Administering contrast media through or into the rectum or artificial opening into the body.
- Tattooing.

Take note that the application or prescribing of ionizing radiation falls under the Healing Arts Radiation Protection Act (HARP) and is not a controlled act. Since MRI technologists and medical sonographers are not regulated Controlled Act 7 is not authorized to MRTs.

The RHPA only permits MRTs to perform a procedure falling within an authorized act if there is an order for the performance of the procedure from the appropriate health care physician, mainly a physician. In the MRTA, Section 5(1), the exact wording of this requirement is:

“A member shall not perform a procedure under the authority of section 4 unless the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario”.

It is the belief of the OAMRT that the expansion of the authorized controlled acts or portions thereof to MRTs will benefit the public, meet the spirit of the RHPA, therefore permitting procedures associated with the scope of practice parameters to be performed by MRTs without the need of delegation.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

WHY THE REQUEST TO CHANGE THE SCOPE OF PRACTICE

Currently there are three (3) controlled acts being delegated to MRTs. These controlled acts are:

1. Putting an instrument, hand or finger beyond the larynx (Controlled Act 6 iii refers)
2. Putting an instrument, hand or finger beyond the opening of the urethra (Controlled Act 6 iv refers).
3. Putting an instrument, hand or finger beyond the labia majora (Controlled Act 6, v refers).

The three proposed authorized acts are necessary in order to perform specific imaging examinations or radiation therapy treatments. These authorized acts are integral to the practice of medical radiation technology and are, in fact, long-standing practice prior to and since the passing of the RHPA.

Under Controlled Act 6, Radiation Therapists, for example, have to be able to demonstrate the position of the cervix and vagina for patients undergoing radiation therapy for cervical or endometrical cancer. Another example which involves Controlled Act 6 iii, beyond the larynx, sees MRTs relieving an airway obstruction under specific conditions such as tracheotomies. An example of Controlled Act 6, iv, beyond the opening of the urethra, is that MRTs are required to insert urinary catheters for the examination of the bladder, ureters and kidneys.

The OAMRT believes that the proposed authorized acts, which are within the traditional MRTA's Scope of Practice, and international standards, should be legislated as authorized acts under the CMRTO.

The MRTA should be amended to reflect **reality**.

Supporting the proposal is the fact that MRTs are taught the essential competencies in their undergraduate studies. These competencies would act as a foundation to perform the proposed controlled acts.

In the situation of going beyond the labia majora and larynx, MRTs are taught and tested during their basic training on the required skill sets.

In the case of the proposed authorized act of going beyond the urethra, as present data shows, MRTs have the basic competency to have this added to their skill set. In some facilities, MRTs are performing the procedure as a delegated act. The OAMRT knows of no reservations by physicians who have delegated this procedure to their MRT colleagues nor of any concerns about MRT competency.

Practice evidence illustrates that with all the proposed authorized acts, MRTs can and do meet the expectations for performing these acts.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

WHY IT IS IN THE PUBLIC INTEREST

Each of the proposed authorized acts relates directly to the practice of diagnostic imaging and radiation therapy. Further, each is within the envelope of the Scope of Practice Statement for the profession.

The request meets the intent and spirit of the RHPA in terms of providing choice and providing

alternative means of health care delivery.

The OAMRT believes that there will be an improvement in the standard of delivery of care due to the proposed change. Presently, MRTs perform the authorized acts in question under the delegation of physicians. The situation with the delegation system is that it is institution or site specific. This creates an imbalance concerning the standard of care on the continuum of quality health care. The standard of the procedure varies from site to site. In the delegation process, basic guidelines are utilized but what standards are set, what is taught and evaluated varies. This translates into a situation where the same procedure done on the same patient could vary significantly. This imbalance of quality care would be stabilized if the proposed practices were authorized to MRTs under the MRTA. The CMRTO as the living body executing the MRTA would set the standards of practice for these procedures, monitor them and insure compliance.

Public protection from harm would be increased because patients would have MRTs doing procedures based on provincial and not local standards. It is a step to minimize risk of harm and provides the public with a reference on which they can judge the care they receive.

The authorization to MRTs of the controlled acts would ensure that the patients would deal with one health care provider during a procedure, the MRT. The intervention of several health care providers for the same examination is disturbing to patients, disruptive and has the potential to impact negatively on the desired outcomes. The authorization to MRTs has the potential of providing a better environment while minimizing the risk of error.

It is also in the interest of the public from a disease intervention sense. The authorization to MRTs of the proposed controlled acts has the potential to reduce patient waiting time thus providing a better outcome for the patient.

Another factor concerning the public interest is an economic one. Although it is not a major driver, the potential for cost savings exist as described on page 15. These saved dollars can be used to meet the Minister of Health's objectives.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

WHO ELSE IS PERFORMING THE SAME FUNCTION

The OAMRT has not done specific research in this area but believe that the submissions of the other associations and the Regulatory Colleges will provide the detailed information.

To the Association's knowledge, physicians, registered nurses extended class and registered nurses perform the proposed controlled acts.

Physicians have these Controlled Acts authorized to them, as do midwives and registered nurses.

It is also believed that respiratory therapists have authorized Control Act 6 iii.

It is not known to the OAMRT as to who all or any of the proposed authorized acts have been delegated to or under what conditions.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

COST/BENEFIT ANALYSIS

This area has been addressed in other parts of the submission. To recap, the OAMRT sees savings in terms of reducing patient waiting times and examination times, the use of standardized procedures and lower salary and benefit costs of practitioners doing the procedure. Health professionals currently performing these controlled acts could be released to carry out higher order tasks related to their profession. All of this translates into direct and indirect cost savings.

Defining the time savings and costs is beyond the scope of this submission and is difficult, at best, even within a facility. Common sense and experience dictates that the patient and health care system would benefit with one individual, the MRT, in this case, doing the entire procedure without intervention by another health care provider. The proposal compliments risk management and quality management programs of facilities.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

DELEGATION

It is the position of the OAMRT that if the proposed controlled acts were authorized to the profession, the OAMRT would not support delegating them to non regulated health care providers.

Delegation would reproduce the conditions MRTs now face.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

EDUCATION AND TRAINING

Attached as Annex B is an overview of the educational aspects asked in the questions posed to the OAMRT.

Be advised that the OAMRT have not included copies of curricula, calendars, competencies, etc. as they were aware that the CMRTO will be providing these.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

COMPETENCY

The OAMRT will rely on the CMRTO to issue the maintenance and evaluation competency.

The OAMRT will work with the CMRTO concerning the continuing education of MRTs, regarding these controlled acts. Further, the OAMRT would work with the CMRTO concerning the updating of their Practice Guidelines and providing to its Members, Best Practice Protocols (BPPs) based on the competencies established by the CMRTO for their Standards of Practice. It is important for the OAMRT to partner with the CMRTO on this to ensure the standard is understood by MRTs and practiced in the same manner in all facilities.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

MEMBERSHIP SUPPORT AND IMPACT

The proposal was put forward to the OAMRT Membership in several ways. The Board of Directors received a copy of the referral and discussed it at a Board meeting. The referral was also sent to the Presidential Advisors, Standing Committee Chairs, Representatives to the national association's Committee on Education and to Section or regional Chairs.

The Members had also been surveyed the past two years.⁶

The response from the "grass roots" area was positive. The general comment was: "why not; we are doing it anyway." Other comments revolved around pressure being exerted on the MRT to do these controlled acts to allow radiologists, registered nurses, etc. to do more appropriate tasks relating to their skill set.

In short, the Membership in general supports the proposed authorization of these controlled acts.

The impact appears to be minimal. Those who are already performing the procedures as a delegated act can see very little impact.

There could be some resistance in some quarters as some MRTs could be apprehensive because it is their nature, they have not researched the issue or feel it is another duty they do not have time for. OAMRT surveys done at the "grass roots" level indicate that this sector of the profession is very small.

⁶ 1997, 1988 OAMRT Annual Membership Surveys

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

OVERLAP

The OAMRT sees the granting of the proposed authorized acts as a positive step for the delivery of health care.

There will be overlap but, this redundancy, as some might view it, is a good thing in the opinion of the OAMRT. It provides the public with choice and provides the health care system with back up resources. It also facilitates understanding and partnership between providers who have the same skill sets concerning these controlled acts.

The OAMRT would expect that the CMRTO would work in partnership with the other professions that have the same authorized acts in setting the standards. It would be important for quality assurance reasons that the standards are the same across the professions for the same procedure.

REQUEST FOR A CHANGE IN SCOPE OF PRACTICE UNDER RHPA

CONCLUSION

The OAMRT supports the proposal to have authorized to MRTs the right to perform controlled acts, specifically: **putting an instrument, hand or finger beyond the labia majora; beyond the opening of the urethra and beyond the larynx** for the procedures described.

The MRT profession is a rapidly changing and evolving profession, therefore, the request is consistent with that evolution.

This authorization would recognize the present environment and ongoing evolution.

The public will be protected through the development, implementation and enforcement of consistent standards of practice and identified competencies established by the CMRTO. This will ensure consistency of performance of these procedures which cannot be guaranteed under the delegation process. Consistency of performance will contribute to reduced patient waiting times, better utilization of health care providers and cost savings.

MRTs have the skill base for this change in their scope of practice. Their practice requirements do include these controlled acts, but under delegation. Authorizing the proposed controlled acts is a natural evolution of the practice.

ADMINISTRATIVE INFORMATION

A. **ORGANIZATION**

1. The organization submitting the response is the:
Ontario Association of Medical Radiation Technologists

B. **ADDRESSES**

2. The physical address of the organization is:
233 Colborne Street, Suite 101, Brantford, Ontario N3T 2H5
3. The mailing address of the organization is:
P.O. Box 1054, Brantford, ON N3T 5S7
4. The Web Site address is : www.oamrt.on.ca
5. The email address is: inquiries@oamrt.on.ca

C.. **TELEPHONE**

6. The telephone numbers are:
1-800-387-4674
519-753-6037
FAX 519-753-6408

D.. **CONTACT PERSON**

7. The contact person is:
R.C. Hesler, Executive Director
519-753-6037
519-753-6408 (FAX)
robinh@oamrt.on.ca

E.. **INFORMATION CONTACTS**

8. Appendix 1 contains a list of the information contacts.

F.. **LIST OF OFFICERS AND DIRECTORS**

9. The list is attached as Appendix 2 to this Annex.

G.. **AFFILIATIONS**

10. The list is attached as Appendix 3 to this Annex.

LIST OF INFORMATION CONTACTS

- Audrey Lawrence, Director of Education
CAMRT
130 Albert St., Suite 1510
Ottawa, ON K1P 5G4

- Terry West
Secretary General, ISRRT
170 The Donway West, Suite 404
Don Mills, ON M3C 2G3

- Alain Crompt
Executive Director
OTRQ
420-7400 boul Les Galeries d'Anjou
Anjou PQ H1M 3M2

- Ontario Hospital Association
200 Front Street, Suite 2800
Toronto, ON M5V 3L1

- Anne Robertson
President, Ontario Association of Radiology Managers
Diagnostic Imaging
Grey Bruce R.H.C.
Box 1400
Owen Sound ON N4K 6M9

- Ellen Charkot
Manager, Diagnostic Imaging Department
Hospital for Sick Children
555 University Ave
Toronto ON M5G 1X8

- Roberta McCammond, MRT(T), RTT
Radiation Therapy Department
Princess Margaret Hospital
610 University Ave
Toronto ON M5G 2M9
- Marcia Smoke, MRT(T), RTT
Radiation Therapy Department
Hamilton Regional Cancer Centre
699 Concession Street
Hamilton ON L8V 5C2
- Lynne McCutcheon
Manager, Diagnostic Imaging
Chedoke-McMaster Campuses
Hamilton Health Sciences Corporation
Box 2000, Station A
Hamilton ON L8N 3Z5

LIST OF OFFICERS AND DIRECTORS

OFFICERS

President:	David Wilson
Vice President:	Karen Ann Johnson
Secretary:	Glynne Richard
Treasurer:	Sharon Faingold
Past President:	Donna Lewis
Executive Director:	Robin C. Hesler

DIRECTORS

Gerry deVette
Wenda Lalande

EX OFFICIO DIRECTOR

CAMRT Director: Mary Jon Lachance

AFFILIATIONS

CAMRT

130 Albert St., Suite 1510
Ottawa, ON K1P 5G4

ISRRT

170 Donway W., Suite 404
Don Mills, ON M3C 2G2

EDUCATION OF THE MRT

A. OVERVIEW

1. MRTs, depending on the Discipline, come through a different undergraduate training streams. Some come out of Programs under the jurisdiction of the *Minister of Health* and others under the *Minister of Training, Colleges and Universities*.
2. All the Programs are guided concerning their curriculum development by practice competencies developed and provided by the CAMRT.
3. All graduates of the training programs, regardless of Discipline, write the CAMRT Certification Examination.
4. The CMRTO, for entry into practice, has adopted the CAMRT Certification Examination as their examination.

B. PROPOSED AUTHORIZED ACTS

5. Appendices 1, 2 and 3 deal with the education and training of MRTs concerning the proposed authorized acts.

PUTTING AN INSTRUMENT, HAND OR FINGER BEYOND THE LARYNX

INTRODUCTION

1. This procedure is conducted by MRTs in the Discipline of Radiation Therapy. This controlled act is done in association with conducting procedures using ionizing radiation.

TRACHEAL SUCTIONING

1. Tracheal suctioning is a procedure used to relieve an airway obstruction caused by tracheobronchial secretions, with the insertion of a catheter attached to a vacuum into a tracheostomy tube. This procedure is a necessary skill for Radiation Therapists involved in the treatment of patients with tracheostomies.

EDUCATION AND CERTIFICATION OF RADIATION THERAPISTS

1. In the past, all students enrolled in a radiation therapy educational program participate in a program of no less than 28 months in length, comprising a minimum of seven months didactic and seventeen months of clinical education, based on the Curriculum Guide of the Canadian Association of Medical Radiation Technologists (CAMRT).
2. Radiation Therapists now entering training are entering a degree program designed specifically for the profession. This program is being provided by the University of Toronto and the Michener Institute of Applied Health Sciences.
3. The Radiation Therapy Student undergraduate training includes comprehensive lectures and examination in Patient Care, Anatomy and Physiology and Pathology, all of which contribute to the Radiation Therapist's understanding and knowledge. Aspects of Patient Care covered include education, assessment, intervention, prevention and care of the patient undergoing Radiation Therapy. More specifically, the Patient Care section of the Radiation Therapy curriculum guide includes a requirement for the student to be able to:
 - a. Explain the purpose and indications for suctioning
 - b. Identify the equipment required to suction and the procedure followed to maintain the equipment
 - c. Explain the techniques for:
 - i. Oral suctioning
 - ii. Suctioning through a tracheostomy

4. In addition, the competent performance of this procedure is set out as a requirement for all students prior to graduation.
5. On completion of the program the graduates must pass a certification Examination prepared by the Council on Education of the CAMRT.
6. All graduates of a radiation therapy program who successfully complete the Certification Examination can apply for registration in the College of Medical Radiation Technologists of Ontario in order to be authorized to practice in Ontario.

PROVIDER COMPETENCE FOR TRACHIAL SUCTIONING

1. The Radiation Therapist must possess a thorough understanding of the purpose and technique of tracheal suctioning, in order to explain the procedure to the patient with confidence, and to perform the procedure safely and accurately.
2. The Radiation Therapist must have the ability to:
 - conduct a patient assessment and be able to recognize the conditions which warrant the use of suctioning (i.e. the signs and symptoms of a lower airway obstruction;
 - follow and adhere to a set protocol; and
 - recognize when informed and proper consent has been given.
3. The Radiation Therapist must understand and recognize:
 - when the procedure has been performed successfully; and
 - potential unexpected outcomes of tracheal suctioning and their management
4. The Radiation Therapist must understand and recognize:
 - any special conditions that a patient might have which may increase the risk for adverse effects of suctioning;
 - Body Substance Precaution procedures and sterile techniques.
5. Instruction in tracheal suctioning is part of a student Radiation Therapist's basic clinical training and the level of skill, knowledge and judgement required to perform this procedure is that required within the routine current practice of a Radiation Therapist.

PUTTING AN INSTRUMENT, HAND OR FINGER BEYOND THE URETHRA

INTRODUCTION

1. The subject procedures are done in connection with imaging studies conducted by MRTs in the Discipline of nuclear medicine and radiological technology and in connection with x-ray simulation in the treatment planning process done by MRTs in the Discipline of radiation therapy.

DESCRIPTION OF PROCEDURES

1. With respect to the proposed authorized act, putting an instrument, hand or finger beyond the opening of the urethra, Medical Radiation Technologists (MRTs) in all three Disciplines are currently delegated this controlled act.
2. In the Discipline of Radiography and Nuclear Medicine, MRTs are delegated this controlled act to carry out urinary catheterization specifically for conducting voiding cystourethrography imaging studies. Voiding cystourethrography is a routine diagnostic procedure and the catheterization of the patient, both insertion and removal, is an integral part of the procedure and has thus become part of the scope of practice for Medical Radiation Technologists in the application of ionizing radiation for the purpose of urinary studies.
3. Two new imaging services - Coincidence Imaging and Positron Emission Tomography - are further increasing the demand for MRTs to catheterize the patient to drain the urine from the bladder. These two new Nuclear Medicine studies based on new radiopharmaceuticals enhance oncology studies that require the bladder to be empty to better visualize the pelvic area.
4. Voiding cystourethrography is a routine diagnostic procedure particularly in children and the catheterization of the patient is an integral part of this imaging study conducted by MRTs in the Disciplines of Nuclear Medicine and Radiography. The Medical Imaging Department at the Victoria Hospital in London reports that there are approximately four hundred voiding cystourethrography examinations, including the catheterization of the patient, done annually by MRTs at that site.
5. Our information indicates that in most centres in Ontario, where pediatric urinary studies are conducted, the MRT is delegated the controlled act, putting an instrument, hand or finger beyond the opening of the urethra by the physician in order to catheterize the patient to conduct the routine procedure of voiding cystourethrography.

6. In the Discipline of Radiation Therapy, cystograms and urethrograms, require urinary catheterization in x-ray simulation in the treatment planning process for cancer of the prostate and cancer of the bladder carried out in radiation therapy sites in Ontario. MRTs in the Discipline of Radiation Therapy are delegated the controlled act, putting an instrument, hand or finger beyond the opening of the urethra by the radiation oncologist to conduct this routine procedure in association with the application of ionizing radiation.
7. Carcinoma of the prostate is the second most common cancer in men and represents approximately 20-25% of the workload in most radiation therapy departments. Patients may be treated with external beam radiation or by inserting a radioactive substance directly into the tumour. Whatever the treatment modality, accurate localization of the prostate and surrounding sensitive organs is vital to delivering accurate treatment and minimizing normal tissue damage.
8. Planning cystograms and urethrograms are very common procedures (at Toronto Sunnybrook Regional Cancer Centre there is an average of 10 per week). Planning cystograms are performed on men for whom radiation therapy is the primary treatment modality and planning urethrograms are performed on those patients who have already undergone radical prostatectomy.
9. In order to localize the prostate and delineate the surrounding organs, the patient must be catheterized. Using a foley catheter, contrast medium is first injected to inflate the catheter balloon. The catheter is then positioned at the base of the bladder to localize the prostate. Contrast is then injected through the catheter into the bladder itself. Frequently barium is then injected into the rectum via a rectal tube to outline the rectum and the other part of the prostate.
10. Urethrograms do not involve actual catheterization of the patient but instead involve the direct injection (via syringe) of contrast medium into the urethral opening to delineate the urethra.

PROVIDER COMPETENCE AND TRAINING

1. Urinary catheterization is the introduction of a catheter through the urethra into the bladder for the withdrawal of urine. A catheter may be left in for continuous drainage or it may be left in only long enough to collect urine according to the purpose of the catheterization.
2. Urinary catheterization is a relatively low risk procedure. The main risk is introduction of infection, which can be controlled with proper sterile technique. There are also risks associated with abnormalities, which can be minimized by assessing the patient's history. Where there is a suspicion of an anatomical problem or significant urethra pathology, the procedure can be performed by a physician.
3. Medical Radiation Technologists obtain the knowledge of the urinary tract anatomy and the knowledge and skill of the aseptic technique used for this procedure in their educational program.

4. The OAMRT supports the protocol and advice the CMRTO provides before accepting the delegation of inserting a catheter through the urethra into the bladder and injection of contrast media through the urethra.
5. We consider the following as a best practice protocol:
 1. a written procedure for the delegation of urinary catheterization must be in place. It will serve as a record for MRTs accepting the transfer of authority from the delegator, who is a member of the regulated health profession, authorized by the RHPA, to perform the controlled act procedure urinary catheterization;
 2. that the delegator has the knowledge, skill and judgement to perform and delegate the procedure;
 3. that the MRT has the knowledge, skill and judgement to perform the procedure safely, effectively and ethically;
 4. that should the MRT decide to undertake the delegated act, they are accountable for that act;
 5. those who have the authority to perform urinary catheterization by means of a delegation may be responsible to ensure that informed consent is obtained prior to the implementation of the procedure and to ensure informed consent is continued throughout the procedure;
 6. that the MRT must have determined the appropriateness of accepting delegation having considered:
 1. the patient's overall condition and care needs when undergoing the procedure;
 2. the known risks and benefits to the patient of performing the procedure; and
 3. the outcomes of performing the procedure; and
 7. that the MRT must have reviewed the circumstances in the situation:
 1. the MRTs degree of independence when performing the procedure;
 2. the need/availability of resources to consult or intervene and the availability of other safeguards in the situation;
 3. the opportunities to maintain competence;
 4. the structures, processes and authorizing mechanisms in place enabling the MRTs to meet legal requirements; and
 5. other factors specific to the patient or situation.
6. Currently Medical Radiation Technologists accept urinary catheterization as a delegated act. Although MRTs have acquired the knowledge necessary to perform the procedure based on their study of urinary tract anatomy and asepsis, the skill to use the necessary equipment and supplies has to be acquired through certification in the procedure at the individual facility. As a result, the competencies to perform the delegated act and the standard of practice to carry out the procedure are different from site to site.

7. MRTs are trained and delegated to do this controlled act to provide timely and efficient performance of urinary studies in Diagnostic Imaging and Radiation Therapy Departments. Unfortunately, demands for other health care practitioners, such as nurses, who are currently authorized to conduct this controlled act have increased and if MRTs do not have the appropriate delegation in place, patient waiting time is increased, which can have a negative impact on waiting lists. Currently the delegation process under RHPA is evolving and therefore the process of delegation is both complicated and inconsistent in health care facilities in Ontario. In terms of patient care this authorization to MRTs will ensure that patients undergoing this sensitive procedure will deal with one caregiver (the MRT) for the entire procedure rather than dealing with a number of health care professionals.

PUTTING AN INSTRUMENT, HAND OR FINGER BEYOND THE LABIA MAJORA

INTRODUCTION

1. This procedure involves the Discipline of Radiation Therapy where Radiation Therapists perform the subject controlled act in carrying out ionizing radiation procedures.
2. It should be noted that should medical sonography be accepted as a specialty and regulated under the RHPA through the CMRTO, this controlled act will apply to them.

INSERTION OF A VAGINAL MARKER

1. The insertion of a vaginal marker involves the controlled act of putting an instrument, hand or finger beyond the labia majora. A vaginal marker is inserted prior to a simulation (x-ray imaging) for the localization of treatment fields for radiation therapy to the pelvis. The vaginal marker (also known as a vaginal dummy) is a radiopaque instrument used to demonstrate the position of the cervix and vagina during the localization of the radiation target volume. It is used in patients with cervical or endometrial cancer, especially in the absence of a Michel clip of radioactive seeds placed during surgery. The procedure requires the insertion and removal of the vaginal marker at the time of simulation.

EDUCATION AND CERTIFICATION OF RADIATION THERAPISTS

1. The educational and certification requirements were described in Appendix 1 to Annex B.
2. Below is information related to the CAMRT Curriculum Guide, Clinical Radiation Therapy section:

The placing of the vaginal marker against the cervix enables the localization of the radiation treatment fields. As such, the insertion of the vaginal marker is an essential component of the simulation procedure and is included in the Clinical Radiation Therapy section of the Curriculum Guide under:

- .08 For Cervix, Endometrium, describe and explain:
- .02 Simulation and localization procedures

PROVIDER COMPETENCE FOR INSERTION OF A VAGINAL MARKER

1. For Radiation Therapy, often vaginal applicators are inserted into the vagina by the therapist prior to simulation for outlining the top of the vagina. The applicator is a solid tube made of plastic with radio-opaque wire imbedded in it. It allows Radiation Therapists to visualize the location of the cervix, or rather where it was before surgery. As well, other vaginal markers may be used in the surface of the perineum or just outside the vagina to indicate the surface. All of this is done inside the labia majora.
2. The competent performance of this procedure is set out as a requirement for all students prior to graduation. The Simulator is a diagnostic x-ray unit used specifically for the localization and verification of radiation therapy fields. Only the Radiation Therapist is present at all times in the Simulator and is qualified to operate the x-ray unit and to ensure the care and safety of the patient.

The Radiation Therapist must possess an understanding of the purpose and technique, in order to explain the procedure to the patient with confidence, and to perform the procedure safely and accurately.

3. The Radiation Therapist must have the ability to:
 - understand and follow a set protocol;
 - effectively communicate details about the procedure; and
 - reassure the patient during the course of the procedure.
4. The Radiation Therapist must be able to recognize:
 - through discussion with the patient and through observation, determine any contraindication to perform the procedure;
 - when a patient is withdrawing consent for the procedure;
 - any changes in patient condition during the procedure; and
 - the successful application of the procedure.
5. The level of skill, knowledge and judgement to perform this procedure is required within the routine current practice of a Radiation Therapist assigned to the Simulator.

PROTOCOLS

A. INTRODUCTION

1. This Annex provides examples of various protocols or procedures which involve the performing of the proposed authorized acts.

B. PROTOCOLS AND PROCEDURES

2. Appendix 1 provides the protocol or procedure for the insertion of vaginal markers.
3. Appendix 2 describes the protocol or procedure involving tracheal suctioning.
4. Appendix 3 is the protocol or procedure for the insertion of a catheter for a cystogram and/or urethrogram.

PROTOCOL OR PROCEDURE FOR INSERTION OF VAGINAL DUMMY OR TAMPON

DEFINITION

1. The vaginal marker (dummy) is a plastic cylinder with a thin wire around the sides OR a tampon (complete with applicator and wrapping) which has been dipped into a barium sulphate suspension prior to use.

RATIONALE

1. This procedure is ordered by the Radiation Oncologist in order to assist in the localization of pelvic radiation treatment fields for patients with cervical or endometrial cancer, especially in the absence of a Michel clip or seeds placed during surgery. The procedure may be performed by any physician or Radiation Therapist [MRT(T)].

PREPARATION OF EQUIPMENT

1. Ensure that the procedure has been ordered by the attending Radiation Oncologist in writing on the treatment record or the simulator requisition.
2. Maintain the privacy of the patient by ensuring that all curtains and doors are closed.
3. Wash hands prior to the procedure and don gloves.
4. When using a plastic cylinder, remove the cylinder from the sterile packet and attach the handle. Place the dummy into the thumb of a clean glove and twist the remainder of the glove around the handle. Tape into position;

OR

When using a tampon, dip the tampon (complete with applicator and wrapping) into a barium sulphate suspension before inserting it into the thumb of a clean glove. Twist the remaining part of the glove to form a handle (ensuring that no barium leaks out).

5. Place the prepared cylinder/tampon into a clean kidney basin.

6. Provide K-Y Jelly for lubrication and skin tape to secure the cylinder/tampon in place.

PREPARATION OF THE PATIENT

1. Check the patient's identification and introduce yourself and your colleagues.
2. Explain to the patient that the procedure has been ordered by the physician and ensure that the patient has a full understanding of what the procedure entails. **IT IS ESSENTIAL THAT THE PATIENT HAS GIVEN INFORMED CONSENT TO THE PROCEDURE.** Provide any further information that the patient requires or arrange for the patient to discuss any concerns with the radiation oncologist before continuing.
3. Provide the patient with privacy to remove any clothing from the waist down, and don a gown.
4. Assist the patient to lie down on the simulator table, in a supine position, and cover with a drape sheet.
5. Question the patient regarding any recent gynaecological surgery or skin reactions, or the presence of any vaginal bleeding or discharge. If any abnormalities are noted, or if the patient has any particular concerns, discuss them with the physician before proceeding.
6. Reassure patient throughout.

PROCEDURE FOR INSERTION OF VAGINAL CYLINDER OR TAMPON

1. No more than two staff members should be present in the room during the procedure.
2. Wash hands and don clean gloves.
3. Have the patient bend her knees, placing her heels together and letting her legs fall apart.
4. Suggest that the patient take slow, deep breaths, then gently insert the lubricated marker into the vagina until it lies against the cervix.
5. Tape the handle into position between both thighs (not to one leg as this may allow the marker to slide into the anterior or posterior fornix).
6. Reassure the patient and, keeping her knees together, assists her to turn over into the prone position if required for treatment.

REMOVAL OF VAGINAL CYLINDER OR TAMPON

1. On completion of simulation, the marker may be removed by either the physician or a MRT(T).
2. If bleeding or any new symptoms are observed, the physician must be informed.
3. Body substance Precautions (BSP) must be observed:
 - a. Hands must be washed and gloves worn;
 - b. If a vaginal cylinder has been used, the glove must be discarded into a yellow BSP bag.
 - c. The vaginal cylinder should be washed with soap and water, then sent for autoclaving;
 - d. If a tampon has been used it must be discarded into a yellow BSP bag;
 - e. Remove gloves and wash hands.
4. Continue to give assistance and reassurance to the patient throughout the procedure.
5. Following the procedure, allow the patient time and privacy to dress. A sanitary pad should be offered if necessary.
6. Inform the patient that some bleeding may be observed after the procedure, but that, if bleeding is heavy or prolonged, she should seek medical assistance.
7. Assure the patient that this procedure is a routine part of the treatment planning process - is unlikely to be repeated during the course of treatment.

DOCUMENTATION

1. Insertion and removal of the vaginal marker must be documented on the patient's chart in the "Patient Care" Section. State that the procedure was explained to the patient and that she gave consent. Describe any problems that were experienced and actions taken.
2. Document the procedure on the patients' treatment record.

PROTOCOL OR PROCEDURE FOR TRACHEAL SUCTIONING

PURPOSE

1. To outline the responsibilities when performing suctioning.

EQUIPMENT

1. This includes:
 - a. Regulator for continuous wall suctioning
 - b. Disposable connecting tubing (2)
 - c. Disposable liner bag with lid attached
 - d. Collection canister
 - e. 5-in-1 connector adaptor
 - f. Suction catheter (14, French)
 - g. Disposable gloves
 - h. Plastic cup
 - i. Optional Equipment: Mask, goggles, gown

ASSEMBLY OF SUCTIONING APPARATUS

1. Collect the equipment
2. Firmly extend the liner bag
3. Place liner bag inside the canister, thumb tab facing yellow tee, snap lid firmly onto the canister
4. Attach patient tubing to free connector on lid
5. Attach liner bag tubing to yellow tee
6. Connect vacuum source tubing to yellow tee
7. Attach suctioning regulator and adapter
8. Connect vacuum source tubing to suction source and turn it on. Allow the liner bag to open and stick to the canister wall before initial use on patient.

PERFORMANCE OF SUCTIONING

1. Prepare the patient by explaining the procedure and raising the head of the bed. If the patient is unconscious position him/her with head turned to one side.
2. Put on personal protective equipment.
3. Turn on suction regulator to a maximum of 120 mm Hg and attach the suction catheter to the tubing.
4. Suction a small amount of water from the cup to test the apparatus and to lubricate the catheter.
5. Gently insert the catheter without applying the suction into the tracheostomy tube slightly beyond the end of the tube. Do not use force. Deep insertion might scratch or perforate the tumour and cause bleeding. If unable to insert catheter, notify the physician.
6. To apply suction, occlude the vent and rotate the catheter while withdrawing it. Suction no longer than 10-15 seconds.
7. Repeat the suctioning as needed. Allow the patient to rest between suctionings and to breathe as necessary.
8. Discard suction catheter in the regular garbage and leave equipment set up in the room.
9. Reposition the patient for comfort and for treatment.

DISCONNECTION AND DISPOSAL OF EQUIPMENT

1. Disconnect the patient tubing with the vacuum source still on.
2. Disconnect the liner bag tubing from the yellow tee and attach it to the freed connector, creating a tightly closed system.
3. Turn the vacuum off.
4. Using the thumb tab on the lid, pull liner bag up.
5. Discard disposable liner bag and the lid system with its contents. Sanguineous drainage must not be discarded into the regular garbage but placed into the biohazardous waste disposal system.
6. Return the cannister to the central supply if it needs to be cleaned; otherwise leave it on the wall.

DOCUMENTATION

1. The procedure must be documented on the patient's chart in the "Patient Care" Section and, if an In-patient, the Nurses' Notes section of the Hospital chart. State the procedure was explained to the patient and that consent was given. Note the odour, colour, amount and consistency of the secretions, frequency of suctioning and patient's tolerance of the procedure.
2. Document the procedure on the patient's treatment record, noting the frequency and timing of suctioning.

PROTOCOL OR PROCEDURE FOR INSERTION OF A CATHETER FOR A CYSTOGRAM

DEFINITION

1. Urinary catheterization is the introduction of a catheter through the urethra into the bladder for the withdrawal of urine. A catheter may be left in for continuous drainage or it may be left in only long enough to collect urine according to the purpose of the catheterization.

RATIONALE

2. Urinary catheterization is performed to relieve urinary retention, obtain a sterile urine specimen as an aid in diagnosis, allow accurate measurement of urine output and determine the amount of residual urine in the bladder after the patient has voided, and to introduce contrast media for diagnostic procedures. Also, to prevent skin breakdown related to incontinence, to maintain an empty bladder so as to prevent injury to adjacent organs during surgery; and to provide bladder irrigation.

CYSTOGRAM

Preparation of Equipment and Patient

3. This is a sterile procedure. One person performs the procedure and one person assists.
 - The assistant places incontinence pad under patient and opens catheter tray using aseptic technique.
 - Ensure a suitable pair of sterile gloves is available for the person performing the procedure.
 - The person performing the procedure drapes the genital area with sterile towels and disinfects the urethral opening with the solution provided.
 - The assistant opens catheter package and drops sterile catheter onto the sterile tray.

- The assistant opens xylocaine lubricant and drops on tray. The person performing the procedure inserts the anaesthetic followed by the lubricated catheter.
- Air or sterile water is used to inflate catheter balloon.
- Contrast media is then inserted into the bladder via the catheter. The end of the catheter is clamped.
- Proceed with simulation or diagnostic procedure.
- Upon completion of procedure, deflate the catheter balloon.
- Unclamp catheter and drain bladder as much as possible.
- Encourage the patient to keep their bladder well flushed with clear fluids for 24 hours.