ENDOSCOPY TELEMENTORING: A QUALITY IMPROVEMENT PROJECT IN RURAL BRITISH COLUMBIA

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Acknowledgements

This project was completed on the unceded and traditional territory of the Ktunaxa Peoples. Support for clinical coaching was through the Rural Coordination Centre of British Columbia’s Rural Surgical and Obstetric Network.
Introduction

It is important for rural patients to have equitable access to high level medical care close to home.¹ The movement towards this in British Columbia started with a joint position paper from the Society of Rural Physicians of Canada (SRPC), The Society of Obstetricians and Gynaecologists of Canada (SOGC), The Canadian Association of General Surgeons (CAGS), and the College of Family Physicians of Canada (CFPC).² This joint position paper on rural surgery and operative delivery created a common groundwork for starting and growing rural surgical programs.² Rural surgical care is being strengthened in BC and Western Canada with an increasing number of patients getting access to local operative delivery, local trauma services being bolstered by enhanced training, and strong remote presence technology access that is connecting urban and rural physicians for support during emergencies as well as coaching and simulations. The technology for remote presence coaching and telementoring has grown over the past decade into a reliable and valuable tool. Every remote or rural hospital in British Columbia now has access to real-time virtual support (RTVS) where the physicians can connect with specialists remotely using audio-video technology.³ Using technology for continuing professional development or for learning new skills has been researched in the area of surgery. In particular, laparoscopic surgical and robotic techniques have been a popular skill for remote telementoring.⁴ American rural surgeons were surveyed and showed interest in telementoring for both learning new techniques and for assistance with unexpected intra-operative findings.⁵

Mentoring relationships are commonplace in business and academia but are not a given when practising as a physician. A mentor is an instructor and a counsellor who is experienced enough to assist another physician in navigating a variety of areas.⁶ The relationship can foster the clinical, technical and personal growth of the mentee. Clinically, a mentor can discuss a case and allow for a conversation around management. More than a simple consult, the conversation is mentee-lead and takes into account the ongoing relationship. In rural areas, a mentor may be difficult to engage because an appropriate one may not be located in the same community. In a large urban hospital, a men-
tor may be in the operating room next door and can be called upon to help assess a course of action, or give technical or clinical advice. In rural Fernie, British Columbia there is only one procedure room operating at a time. Using simple technology, tele-mentoring can almost place a remote mentor in the room with the rural mentee. With readily available technology a mentor can see the clinical situation as well as the mentee. For example, in endoscopy, the mentor can see a direct feed from the scope for clinical information, as well as have a view of the mentee to remind them of ergonomics and give other career-prolonging advice.

A literature review shows a dearth of studies and reviews on endoscopy telementoring. There are no RCTs, only small case studies that demonstrate the challenges and benefits of surgical skill sharing through remote technology.4

A large part of the practice of a family physician with enhanced surgical skills (FP-ESS) is endoscopy.7 FP-ESS is a category 1 certificate of added competency recognized through the College of Family Physicians of Canada. FP-ESS work in small, rural or remote communities. Unpublished PopBC data analyzed through the RSON project in the Northern and Interior Health Authorities in BC shows that FP-ESS do around 1000 endoscopy procedures per year in the five rural sites of Fernie, Golden, Revelstoke, Vanderhoof, and Smithers (Email communication between RSON project manager T. Skinner and author, 2022). The FP-ESS provide colon cancer screening, polyp removal, upper endoscopy, biopsies, management of GI issues within their skill set, and the recognition of what needs specialist referral.7

Currently there are funded coaching programs in BC through the RSON (Rural Surgical and Obstetrics Network, RCCBC).8 These programs focus on maintaining and improving rural surgical and obstetrics care in rural BC. Marrying this program with the RCCBC RTVS technology is a natural step for rural mentorship programs and can be utilized, in this case, for supporting rural endoscopy.

The desire for a mentorship relationship and the problem of rural isolation prompted this local quality improvement project. We explore if mentorships using remote presence technology in endoscopy are valuable from the viewpoint of the mentor and mentee. We
outline how this simple project ran in order to spark interest in other rural communities who may be looking for ways to build similar physician support networks which ultimately may improve patient care and prevent physician burnout.9

**Aim and objectives**

The objectives were to form a telementoring relationship between a rural FP-ESS and a gastroenterologist in order to utilize intra-endoscopy remote presence technology for mentorship. Through the mentorship the FP-ESS would enhance their endoscopy skills and knowledge as well as feel supported in a surgical network.

A structured qualitative evaluation of the remote presence telementoring quality improvement project aimed to discern the value of the project for the participants and highlight any barriers to address for the development of future telementoring projects

**Methods**

**Study Type**

The approach to this project is one of an improvement study. Quality improvement studies lend themselves to small data sets focusing on local problems using local knowledge.10 As a project with small numbers, the way of understanding the project’s value was largely by qualitative data. Qualitative methodologies gather deep insights into how participants feel about the project and allow for an understanding of opinions with respect to each step in the project. Replicating quality improvement projects is notoriously difficult11 therefore open-ended questionnaires allowed the participants to give local context to the issues further allowing other rural communities to identify with issues addressed.

Prior to the telementoring project, two endoscopy days were done by the FP with the GI physically present and coaching in October 2021. These days were important to do clinical coaching, gain rapport, and comfort with feedback styles. The patients were chosen by the gastroenterologist and the FP performed the endoscopies with patient consent. The GI gave feedback on endoscopy ergonomics, scope control, polypectomy techniques, and clinical management of pathology. These days were financially supported
by the RCCBC RSON clinical coaching program’s sessional payments to the GI while the FP billed MSP for the procedure.

The ad hoc telementoring sessions started in November 2021. The GI was available for the FP to contact them any time they needed guidance working through an issue, had a clinical question, or unexpected pathology. These calls were in working hours and there was no obligation to offer telementorship if the mentor was unavailable. 5 months of interactions were evaluated. This included 24 endoscopy days where the FP-ESS could have utilized the telementorship.

The questionnaires’ open-ended questions were styled after the basics of the quality improvement Plan-Do-Study-Act (PDSA) framework. This common quality improvement framework encourages an initial recognition of the issue at hand and the aim of the intervention. Following the intervention, the PDSA framework suggests that there should be simple questions to elicit if the project was a success but also deeper probes to elucidate any side-effects, barriers encountered and possible future projects. The questionnaires were sent by email for the mentee and mentor to complete at a time that was convenient. Questionnaire #1 was completed by the mentee to understand the rural endoscopy challenges and help plan the telementoring needs. Questionnaire #2 gathered information about the telementoring intervention and questions were based around highlighting the successes and challenges of the intervention, ie. the outcomes and personal experiences. The mentor and mentee reflected on areas of skill development, technological implications, and if a benefit to the rural endoscopy program occurred with the quality improvement project. An additional question for the mentee used a 5-point Likert scale to rate their level of comfort with different endoscopy procedures. This procedural question was identical on both questionnaires for comparison. See appendix A for questionnaires.
Table 1. Project Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>October 2021</td>
<td>In person endoscopy coaching days (two)</td>
</tr>
<tr>
<td>November 2021</td>
<td>Questionnaire #1 Planning (mentee)</td>
</tr>
<tr>
<td>November 2021 through March 2022</td>
<td>Ad hoc Remote Telementoring sessions (six)</td>
</tr>
<tr>
<td>March 2022</td>
<td>Questionnaire #2 Experience and Outcomes (mentee and mentor)</td>
</tr>
</tbody>
</table>

Analysis

A thematic analysis was done on the written responses to the questionnaires. The mentor and mentee’s answers were coded into themes using a traditional manual method. Phrases and sentences were highlighted that expressed a feeling, an opinion or described an experience. These phrases were sorted into themes and the most common themes were focused on. Each individual answer to the Likert scale procedural question was compared pre-telementoring and post-telementoring. The change, or lack of change, in Likert scale numbers was then compared with the qualitative themes.

Geographical context

Fernie, British Columbia is located in the East Kootenay surrounded by the Rocky Mountains. The referral centre, Cranbrook, is an hour away when the weather cooperates. There are two local endoscopists: an experienced GI and a newer to practice FP-ESS. Prior to the formal mentorship, they had a collegial working relationship. The gastroenterologist supports task sharing with family physicians and believes rural endoscopy by family physicians is a key part of access to sustainable care for rural patients. This community is supported by the RSON RCCBC project and sessional funding was available for the mentorship.

Technology

After trialling different ways to connect, the stakeholders (mentor, mentee, nursing staff setting up the equipment) settled on a system with the best image transfer and quickest set up. A Zoom meeting between the hospital Ipad, the Pentax endoscopy unit and the
mentors iPhone was initiated. All the contacts, who also have RCCBC Zoom accounts, were saved and “favourited” on the Zoom app. The endoscopy monitors were connected directly to the local iPad with an AV cord for an excellent real time image. The local iPad camera with an internal microphone was aimed at the mentee who had to only slightly raise their voice to be heard well by the mentor. It took less than five minutes for one staff member (either a nurse or anesthesiologist) to set it up. See Appendix B for the local flow sheet of instructions to set up the telementoring session.

Example of a telementoring interaction

During a telementoring call, the mentee would present the case, their plan and any specific questions they had. The mentor would then, if needed, present some probing questions to try and allow the mentee to lead the eventual feedback and advice. The feedback was sometimes very brief, other times they suggested additional management plans, or recommendations for techniques were given. If the session was about a technique then they would stay online to support the procedure as needed. For example, polypectomy is a basic part of endoscopy but certain morphologies and locations of polyps can make them difficult. With a direct view of the scope image, the mentor could suggest different light filters to further classify the lesion, or rotating views and have real time image feedback of each change. When this type of call was made to a mentor they gave advice about things such as where to raise the polyp and what type of snare to use. The whole call was typically less than 5 minutes.

Results

Both mentor and mentee felt the mentorship had value and that utilizing remote presence technology was an excellent tool but needed to be adapted for the local group over a trial period.

“The whole team needs to be aware of how to set up the equipment and how to troubleshoot. There were a few iterations of technology. FaceTime with the iPhone pointed at the endo screen by a nurse is the most straightforward but the image for the mentor is not ideal. It is difficult for the nurse to get the lighting right and they are in an odd spot for a while. The mentor cannot see the mentee and give advice on what the scope is actually doing either. So having a direct feed from the scope is necessary.” -Mentee
There were numerous themes that were consistent from mentor to mentee. Both saw this project as a valuable use of resources and a way to bring quality care to a rural location by task-sharing between family physicians and specialists.

“It is possible that endoscopy can be done by high quality endoscopists, but not everyone has to be an expert in all GI diseases.” -Mentor

“I certainly feel confident in having safe endoscopy skills but I have not seen as many cases as a specialist gastroenterologist and so, once in a while, I come across a pathology, or finding, that I cannot identify and am not sure how best to proceed. This does not happen very often, but when it did, I was able to show the finding to my mentor in real time, discuss it, and take the specific biopsies she recommended. The patient did not need another scope to complete their workup and I could send them on to specialist care for management.” -Mentee

Both were aware of the scope of the FP-ESS and valued their place in rural settings.

“It is a second set of eyes to help determine the best course of action that might change intervention of an endoscopist, and/or result in avoiding another scope by a different endoscopist.” -Mentor

“It is easy to mention the benefits from the patient’s side. Less travel, not having to drive over an hour for a procedure that requires your bowels to be cleared (avoiding urgent roadside toilet breaks). It is possible that fewer people would do colon screening if they had to travel. Local access increases the health of the local population.” -Mentee

A number of procedures were rated by the mentee on a Likert scale for how confident they were performing these. The mentee increased their confidence for mid-size polypectomy (1 to 1.5 cm and 1.5 to 1.9 cm) over the course of telementoring but was no more comfortable with polyps larger than 2 cm.

“I have a level of comfort for procedures and know my limits.” “A polyp with a 2 cm base is quite large! At this point in my practice I will continue to feel comfortable referring these patients with large and rare lesions to a specialist for management and possibly surgical planning.” -Mentee

The narratives presented by the questionnaires were, for the most part, concordant between mentor and mentee. Where they differed was in their opinion of the relationship building. The mentee valued the in-person coaching days that occurred before the telementoring, knew that being colleagues helped their comfort with receiving feedback and
felt supported in their career by the mentor. Whereas the mentor did not see the prior relationship building before going virtual as a necessity.

“I think that our pre-existing relationship and working with the same OR team helped establish trust. But I don’t think it is essential. It is not really much different than when you phone up a specialist and ask this sometimes stranger for help. Because it is a procedural skill included in the consultation, it is a bit different, but no less harm is likely incurred if the person asking for advice gets bad advice. Secondly, the person seeking help will be able to decide if they like the opinion and advice from remote consultants whether it includes real time video or only phone advice. ie. the person seeking advice will often be able to tell if the advice given is good or garbage.” -Mentor

The timing of the sessions varied. There were no scheduled telementoring sessions, as the calls came up as patient scenarios presented themselves. With one endoscopy suite in Fernie, when the mentee was scoping the mentor was typically running an office clinic. Before starting the mentorship the mentee expressed dismay at a perceived increased burden taken on by the mentor.

“In terms of the remote aspect of it, I worry about taking the time of the mentor. I know they are busy. What makes it a bit easier to bother them, is to have a conversation ahead of time about the types of cases I would call about and that I don’t expect happen all that often. Also the funding component. There is no provincial funding because it is not a formal consult. If there was not a sessional funding fee available, it would just be more unpaid work that could contribute to physician burnout.” -Mentee.

This worry was not born out in the mentor’s experience:

“I am either available or not available. The patient is the main person that stands to gain by intra-operative/intra-endoscopic advice, and a minor interruption of my day is not a big deal.” -Mentor

Discussion

Telementoring in endoscopy was perceived to be useful in this quality improvement project and it will continue to be used in Fernie. The open-ended questionnaires allowed the qualitative data to illuminate the experiences of the physicians involved in the project. This approach to data collection reflected the participants' feelings and experiences. There were common themes of rural physician support and the value of the
technology. The comments from the mentee emphasized not only the value in intra-procedural clinical advice but also the nonclinical areas in which the mentee benefitted from the relationship. Interestingly, the mentor did not think that a prior relationship was important for an intra-procedure call but the mentee did. This may reflect the feeling of isolation the FP-ESS has in being a Non-Specialist physician (NSP) task-sharing by performing endoscopy. Task sharing is where a procedure is done by a “health worker that has shorter training and fewer qualifications”\(^\text{15}\) than a specialist physician due to a shortage of specialists or a lack of volume in areas with small populations. In 2020 Falk did a systematic review of the global surgical trends in task sharing.\(^\text{15}\) It was found that task sharing to NSPs occurs across the globe to varying degrees and could be a solution to close the gap to provide essential surgical services to the 5 billion people who have minimal access. Telementoring could be a support put in a surgical network to enhance the work of NSPs.

The mentee compared their confidence in specific endoscopy procedures before and after telementoring. Their response showed that they were more confident with medium sized polypectomy (1cm to less than 2 cm) but not with greater than 2 cm lesions. This simply reflects their practice scope and trying to avoid situations that are too complicated and should be seen by a specialist surgeon. The size of polyp correlates the risk of cancer being found in that polyp. A polyp larger than 2 cm has a 19.35% chance of being an adenocarcinoma compared with 2.41% in 1-2cm polyps and 0.07% for polyps less than 1 cm.\(^\text{16}\)

Studies have shown that family physicians performing endoscopy have good outcomes and are well trained\(^\text{17}\) but being remote from similar family physician colleagues leaves a gap in mentorship opportunities. Mentorship, especially between women physicians, is an important area of growth in medicine that is gaining momentum by increasing career satisfaction, promoting and maintaining women in all aspects of medicine.\(^\text{18}\) Using telementoring as part of a mentorship relationship in rural areas may be a tool to encourage new-to-practice physicians in their areas of interest and develop networks to reduce burnout and improve retention.\(^\text{19}\)
It is also important to consider the process of telementoring through an ethics lens. It is important that the mentee is already a skilled endoscopist and they are performing procedures that they could continue to perform even if the virtual support technology connection was lost. All endoscopists in Canada must go through the DOPS, Direct observation of procedural skills, assessment and therefore it is understood that the mentees are already meeting quality expectations. The mentee is not taught or encouraged to do something that is out of their practice scope. The Canadian literature does not discuss the liability or legal implications of telementoring but the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) reviewed this issue in 2021. The telementor can be thought of as an informal consultation directly to the surgeon rather than a formal consult on the patient. In the USA, an informal consult is not liable for malpractice.

It has been suggested by the data collected in this quality improvement project that patient care is improved when physicians work in a network and have access to intra-procedure telementoring but this is a limitation of the scope of local Quality improvement project. In the future, a research study involving patient oriented outcomes and quantitative data could be done to understand the impact of telementoring on the endoscopy patient experience including the need for travelling for procedures and repeat procedures.

The next steps of the project could include scaling up endoscopy telementoring to other rural sites in BC. The mentors could be in line with the rural referral pathways in order to create support and networks between local physicians. For example, gastroenterologists from Kelowna could be available to mentor FP-ESS from Revelstoke, GI from Kamloops to support Lillooet and GI or General Surgeons from Prince George to Vanderhoof. The mentoring does not need to go along the referral pathways but it may be an easier place to start because each site has an idea of how the other functions already. In this project, the burden of call did not exceed the ability of the GI to be available. This may be due to the low volume of telementoring requests from the FP. If, in a scaled up project, the mentor felt their day was delayed, or they were too pressured by time to be a guiding mentor there could be a role for an “on-call” telementor. This would
not necessarily be through the typical referral pathways but could be a single GI ready to mentor any endoscopist across the province. The possible downside to this upscaling is the lack of relationship building with a rotating GI telementor. Creative ways to build relationships between endoscopists in the province could be explored such as group rounds or continuing medical education where gastroenterologists, general surgeons, and FP-ESS come together virtually to learn about endoscopy but as a side benefit also learn about the differences and similarities in practice. Overall, this could build relationships and create more urban-rural empathy and awareness.

**Recommendations**

1. The technology for remote telementoring is sufficient to give advice and support a mentee through a specific case. With this support from experienced colleagues, telementoring can bolster task-sharing in rural surgical programs. Support and mentorship decreases the feeling of professional isolation and can place remote programs in a network.

2. A structured telementoring program should be considered by all rural endoscopy sites. Gastroenterologists, general surgeons and FP-ESS in British Columbia should all be approached as key stakeholders in order to facilitate the upscaling of the telementoring program. There is a role for each physician to self-identify, no matter the specialty, as a mentor or mentee. Through telementoring, more patients may have increased access to high quality endoscopy. The number of referrals for repeat colonoscopies may also be decreased thus decreasing healthcare spending. Applications for financial support could be submitted to provincial groups such as RCCBC and the health authorities.
References

Appendix A. Questionnaires

Questionnaire #1 Mentee

1. What are the challenges and benefits of rural endoscopy programs?
2. How confident are you with the following:

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<thead>
<tr>
<th></th>
<th>Not confident at all</th>
<th>slightly confident</th>
<th>somewhat confident</th>
<th>fairly confident</th>
<th>completely confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Polypectomy less than 1 cm</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>B. Polypectomy 1.5 cm</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>C. Polypectomy 1.5-1.9 cm</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>D. Polypectomy over 2 cm</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>E. Endo loop use during polypectomy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>F. Tattooing bowel</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>G. Raising polyps</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>H. Using multiple modalities to control post-polypectomy bleeding</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tr>
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</table>

3. Do you have any hesitations about telementoring or endoscopy coaching?
**Questionnaire #2 Mentee**

1. Do you feel there is value in remote telementoring of FP-ESS colleagues? (did the quality improvement project have value for different stakeholders)
2. Was it important to have a prior, in person, relationship building clinical day with the mentee before accessing telementoring? Why or why not?
3. Did the technology suffice for telementoring? What can be improved?
4. Do you feel your practice has changed since the telementoring relationship was made?
5. Have you accessed your telementor?
   a. Was it beneficial to you during the procedure?
   b. Did it assist in the patient diagnosis or treatment plan?
   c. Did any patient avoid a referral to a larger centre?

6. How confident are you with the following:

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<thead>
<tr>
<th></th>
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<td>F. Tattooing bowel</td>
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<td>G. Raising polyps</td>
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</table>
Questionnaire #2 Mentor

1. Do you feel there is value in remote telementoring of FP-ESS colleagues? (did the quality improvement project have value for different stakeholders)
2. Was it important to have a prior, in person, relationship building clinical day with the mentee before accessing telementoring? Why or why not?
3. Did the technology suffice for telementoring? What can be improved?
4. Was it a burden to be “on call” for your mentees? How did you navigate fielding calls during your own practice?
5. Were there any aspects of telementoring that made you uncomfortable?
6. Do you have any ideas about expanding this program to more mentors and mentees in endoscopy?
7. Is there anything else you would like to add about the project?

H. Using multiple modalities to control post-polypectomy bleeding
Appendix B. Telementoring Equipment Set-Up

REMOTE PRESENCE TECHNOLOGY:
STEP BY STEP PROCESS

- Bring RPT Camera Cart (located by male change room in the OR)
- Bring iPad from OR
- Plug RPT into Wi-Fi
- Plug RPT into power "do not plug in HDMI"

- First, Turn on Trauma iPad by pressing the HOME button, enter password
- Using the touch screen Click Zoom App (bottom left)
- Ensure you are on the ‘HOME’ Screen (legend is on left side)
- Touch ORANGE ‘New Meeting’
- Click ‘Start Meeting’
- Touch iPad screen to have the top menu drop down
- Click on ‘Participants’
- Go to Invite (bottom left), click ‘Invite Contact’ and search options below
- PICK CONTACT for RUDi (ER), MaBAL (Maternity), CHARLiE (Peds), ROSe (Intensivist)

- For RPT Camera Cart Invite H.323/SIP Room System
  1. Enter IP Address: 774051@interiorhealth.ca
  2. Press CALL
  3. On the RPT touch the ‘Answer’
  4. Press mute button on the iPad to avoid interference and turn volume down, at this time you could remove the iPad to either the top up endo room or the OR sterile core.
  5. Plug in HDMI cord and on touch pad press green button “share in call”
  6. Go to top of touch pad video icon and press ‘start self view’

iPad Tips
- On iPad switch to gallery view
- Turn iPad sideways for bigger screen view

- Request camera control if using iPad to change RPT Camera Cart Camera

For additions and changes adjust this document in the F:\Fernie\Share\OR