



Guide for TERMS, CONDITIONS & LIMITATIONS (TCLs) imposed by the CRTO

To practise Respiratory Therapy in Ontario, one must hold a certificate of registration with the College of Respiratory Therapists of Ontario (CRTO)*. Some Members of the CRTO may have Terms, Conditions, and/or Limitations (TCLs) applied to their certificate of registration. These TCLs may be enacted by regulation (e.g., Graduate Certificates) or by one of the CRTO's statutory committees (e.g., Registration Committee). They may also be imposed through an Acknowledgement and Undertaking (A&U) between the CRTO and the Member.

* With the exception of Inter-jurisdictional Respiratory Therapists who meet the conditions under [O. Reg. 199/23 Exemption – Restricted Titles](#), which include having submitted an application for registration to the CRTO.

This guide is intended for Members who are registered with **TCLs imposed by a CRTO Committee or through an A&U**. The information in this guideline will assist Members and their employers in managing the TCLs. The guideline also explains the process for having TCLs removed or modified.

A. TERMS, CONDITIONS & LIMITATIONS

Terms, conditions, and limitations (TCLs) are restrictions placed on a Member's certificate of registration. In general terms, such restrictions are imposed to protect the public. For example, the Registration Committee may direct an RT practice under supervision when the Member has been away from practice for an extended time and does not meet the CRTO's currency requirement. In this case, the supervised practice condition ensures that the Member undergoes the appropriate retraining, monitoring, and assessment before practicing without restrictions. TCLs are part of the Members' public register record and are posted on the CRTO's website. Members registered with TCLs, can apply to the CRTO to have them removed or modified. (see section D). Examples of the TCLs that may be imposed are listed in Table 1.

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TABLE 1 – TERMS, CONDITIONS AND LIMITATIONS THAT MAY BE IMPOSED BY THE CRTO

<p>1. The Member shall, at the first reasonable opportunity, advise every employer of any terms, conditions and limitations that apply to the Member's certificate of registration if their employment is in the field of respiratory therapy.</p>
<p>2. The Member shall only perform a controlled act that is authorized to the profession if it is performed under the general supervision of a Member of a College within the meaning of the <i>Regulated Health Professions Act, 1991</i> who, is authorized to perform the controlled act and is competent to do so and who is available to be personally present at the site where the authorized act is performed on ten (10) minutes notice.</p> <p>In this case, the Member (under general supervision*) may, for example,</p> <ul style="list-style-type: none"> • Perform a prescribed procedure below the dermis (e.g., ABGs, arterial line and IV insertions) • Intubate beyond the point in the nasal passages where they normally narrow or beyond the larynx • Suction beyond the point in the nasal passages where they normally narrow or beyond the larynx • Administer a substance by injection or inhalation
<p>3. The Member shall only perform a controlled act authorized to Respiratory Therapy, to gain competence in that procedure, and only if performed under the direct supervision* of a Member of a College within the meaning of the Regulated Health Professions Act, 1991 who, is authorized to perform the controlled act and is competent to do so.</p> <p>In this case, the Member will need direct supervision*, to, for example:</p> <ul style="list-style-type: none"> • Perform a (basic) prescribed procedure below the dermis (e.g., ABGs, arterial line and IV insertions) • Intubate beyond the point in the nasal passages where they normally narrow or beyond the larynx • Suction beyond the point in the nasal passages where they normally narrow or beyond the larynx • Administer a substance by injection or inhalation
<p>4. The Member shall only perform advanced prescribed procedures below the dermis, for the purpose of gaining competence, and only if performed under the direct supervision of a Member of a College within the meaning of the Regulated Health Professions Act, 1991 who, is authorized to perform the controlled act and is competent to do so.</p> <p>In this case, the Member must be under direct supervision* to, for example, perform:</p> <ul style="list-style-type: none"> • Manipulation or repositioning of a cannula balloon • Chest needle insertion, aspiration, repositioning and removal • Chest tube insertion, aspiration, repositioning and removal • Bronchoscopic tissue sample for the purpose of bronchoalveolar lavage and endobronchial brushing • Intraosseous needle insertion • Subcutaneous electrode placement for interoperative and perinatal fetal monitoring <p>NOTE: To perform any procedure classified as Advanced, a Registered Respiratory Therapist (RRT) must have completed a CRTO-approved certification/recertification program within the past two years. More information is available in the CRTO's Certification Programs for Advanced Prescribed Procedures below the Dermis PPG.</p>
<p>5. The Member shall only perform a tracheostomy tube change to gain competence in that procedure, and only if performed under the direct supervision of a Member of a College within the meaning of the Regulated Health Professions Act, 1991 who, is authorized to perform the controlled act and is competent to do so.</p>

6. The Member can NOT delegate any controlled acts that they do not have the authority to perform without restrictions (e.g., supervision).

7. The Member shall **not accept delegation** for any controlled act.

B. SUPERVISION

Supervision (either direct or general) is an essential aspect of most TCLs imposed by the CRTO. The supervision requirement applies to the performance of controlled acts that are authorized to Respiratory Therapists; that is:

1. Performing a prescribed procedure below the dermis (e.g., ABGs, arterial line and IV insertions)
2. Intubating beyond the point in the nasal passages where they normally narrow or beyond the larynx
3. Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx
4. Administering a substance by injection or inhalation
5. Administering a prescribed substance by inhalation.

The supervision condition may apply to all authorized acts, or in some cases it may only apply to specific authorized acts or procedures. **It is important to note that if a supervision requirement has been imposed for an authorized act, that supervision must be in place each and every time the Member performs that particular authorized act until such time as the supervision condition has been lifted by the CRTO.**

*The supervision requirement may be general (indirect) or direct.

- **GENERAL (INDIRECT) SUPERVISION**

The supervisor** does not need to be next to the Member at all times, but they must be **available in person within 10 minutes**.

An example of general supervision would be an RRT applying CPAP to a new patient while the supervising healthcare professional** is available in person within 10 minutes, to assist with the procedure.

- **DIRECT SUPERVISION**

The supervisor** must be **physically present** at all times when the Member performs controlled acts authorized to Respiratory Therapists.

An example of direct supervision would be a supervising healthcare professional**, physically observing and guiding the performance of arterial blood gas procurement by the Member.

****The supervisor must be a Member of a College within the meaning of the Regulated Health Professions Act, 1991 who, is authorized to perform the controlled act and is competent to do**

so. For example, a respiratory therapist, physician or nurse practitioner may potentially provide supervision to respiratory therapists registered with TCLs.

More information on direct and general supervision can be found in the CRTO's [Supervision Policy](#).

C. MANAGEMENT OF TCLS

Member's responsibilities:

- Members must advise their employers of any terms, conditions, and limitations that apply to their certificates of registration.
- Members must always ensure that they have the requisite knowledge, skills, and judgement/abilities to undertake any aspect of patient care.
- Members are required to act within both their professional and personal scope of practice and adhere to the CRTO standards, which include all relevant legislation, regulations, standards, position statements, policies and practice guidelines.
- Members must identify their learning needs and negotiate a plan to meet their learning needs.

Employer's responsibilities

- Employers need to ensure that they have the necessary provisions in place to support a Member practicing with TCLs. For example, if supervision is required, the facility must have appropriate healthcare professionals available to provide the supervision.
- The employer is responsible for having sufficient resources to provide supervision. This may include providing proper monitoring and assessment.
- Reporting: the employer must report to the CRTO if, for example:
 - The RT was terminated for professional misconduct, incompetence or incapacity.
 - It appears that the RT is incompetent, incapacitated or has sexually abused a patient.

For more information about employers' reporting requirements, please see the fact sheet on [Mandatory Facility/Employer Reports](#).

D. APPLICATION TO CHANGE TERMS, CONDITIONS & LIMITATIONS

A Member subject to TCLs may apply to the CRTO to have the terms, conditions, and limitations removed or modified. If the TCLs were imposed by the Registration Committee (RC), the Member should apply to the RC for their consideration. Alternatively, if the TCLs were part of an A&U, the Member should direct their request to the Registrar. It's important to note that the decision to remove, modify, or maintain the TCLs rests with the TCL or Registrar.

NOTE: TCLs imposed by regulation cannot be varied by a CRTO committee or the Registrar. For example, the Graduate Respiratory Therapist (GRT) with TCLs imposed via s. 60 of the [Registration Regulation](#) (O. Reg. 596/94) cannot have those TCLs varied until they provide the CRTO with evidence that they have passed the HPTC exam.

The application to change TCLs must include documentary evidence that supports the request.

An application to change TCLs should include the following:

- A completed application form (pages 7-9 in this guide);
- Letter of support from employer/supervisor (page 10 in this guide);
- Copies of all relevant Competency Checklist(s) signed and dated by the regulated healthcare professional(s) that provided supervision (pages 11-31 in this guide);
- A completed Supervisor Signature Sheet (page 32 in this guide); and
- Additional supporting documentation may include learning/orientation package(s), and upgrading/refresher courses.

NOTE: Literature reviews, online courses and other didactic activities may be used as part of the application. However, in general, completion of didactic activities alone will not be considered sufficient proof of clinical competence, especially in relation to the controlled acts authorized to Respiratory Therapy.

Once all of the requisite documentation has been submitted to the CRTO, the Member's applications to change the TCLs will be considered. In general, decisions are issued in writing within four weeks of the review date.

After reviewing the application, the CRTO may:

- Remove/modify the TCLs imposed on the Certificate of Registration;
- Request more information from the Member; or
- Refuse the application.

E. COMPETENCY CHECKLISTS

Members who are registered with TCLs that restrict their performance of controlled acts may apply to have the restrictions lifted or modified. In these cases, Members need to provide evidence of competence in those specific controlled acts. This evidence may be presented in the form of competency checklists. This guide provides templates of Competency Checklists (see pages 11-31).

Members applying for a change to their TCLs and their employers may use these checklists as part of their submission to the CRTO. The checklists outline the performance criteria that must be demonstrated under a number of procedures, which are required to demonstrate competence to perform the listed Authorized Acts. Members must show evidence of competence for each procedure on which a TCL has been placed and which they wish to vary or lift. If a Member does not show evidence of competence in some or all of the listed procedures or performance criteria, the CRTO may uphold the TCLs on the Member's registration or vary or lift some but not all of the TCLs.

To be considered as sufficient evidence each procedure would have to be performed under supervision a minimum of five (5) times. The checklist must indicate the dates, environment/patient population(s) and signature of supervisor(s). It does not need to be the same healthcare professional supervising and confirming competency for each instance. However, all supervisors who sign the TCLs Competency must:

- be authorized to provide supervision (please see section D of this guideline);
- observe the Member competently demonstrate the procedure; and
- print their name, provide their professional designation and signature on the enclosed Supervisor Signature sheet.

Please note that evidence of completing a learning/orientation package(s) and/or upgrading/refresher courses may be submitted as supporting documentation, in conjunction with the completed Competency Checklists.

F. TEMPLATES & SAMPLES

- Application for Change to Terms, Conditions & Limitations (see pages 8-10)
- Sample letter of support from employer(s) (see page 11)
- Sample TCL Competency Checklist(s) (see pages 12-31)
- Evaluator Signature Template (see page 32)

G. RESOURCES

- [2016 Respiratory Therapy National Competency Profile](#)
- [CRTO Interpretation of Authorized Acts Professional Practice Guideline](#)
- [CRTO Terms, Conditions & Limitations Fact Sheet](#)
- [CRTO Supervision Policy](#)

H. CONTACT INFORMATION

College of Respiratory Therapists of Ontario

Tel.: (416) 591-7800

Toll-Free: (in Ontario): 1-800-261-0528

Fax: (416) 591-7890

Email: questions@crto.on.ca

Web Site: www.crto.on.ca



APPLICATION for Change to TERMS, CONDITIONS AND LIMITATIONS

College of Respiratory Therapists of Ontario (CRTO) Members who are subjected to terms, conditions and limitations (TCLs) imposed by the CRTO may apply to have them removed or modified. An application to change TCLs should include the following:

- Completed application form;
- Letter of support from employer/supervisor (see TCL Guide – Employer Letter);
- Copies of clinical competency checklist(s) signed and dated by regulated healthcare professional(s); a minimum of 5 sign-offs per competency (see TCL Guide - clinical competency checklist template); and
- Additional supporting documentation (e.g., learning/orientation package(s), upgrading/refresher courses).

FIRST NAME	SURNAME	CRTO Registration No.
EMAIL		PHONE NUMBER

PART 1 - APPLICATION

As a Member of the CRTO Registered with a **General** **Graduate** **Limited** Certificate of Registration with terms, conditions and limitations (TCLs) imposed by the CRTO, I wish to apply to the CRTO to (select one):

- Remove all the TCLs currently imposed on my Certificate of Registration (please skip Part 2 & complete Parts 3, 4 & 5)
- Remove/modify specific TCLs currently imposed on my Certificate of Registration (please complete Parts 2, 3, 4 & 5).

PART 2 - TCLs

A. Supervision - I wish to perform the following procedures without supervision (please check all that apply):

- Prescribed procedure below the dermis - Basic**
 - Arterial, venous and capillary puncture (e.g., arterial puncture).
 - Insertion, suturing, aspiration, repositioning, manipulation and removal of an arterial cannula (e.g., arterial line insertion).
 - Insertion, suturing, aspiration, repositioning, manipulation and removal of a venous cannula (e.g., peripheral IV insertion, internal jugular vein cannulation).
- Prescribed procedure below the dermis - Advanced**
 - Manipulation or repositioning of a cannula balloon (e.g., Pulmonary Capillary Wedge Pressure)
 - Chest needle insertion, aspiration, repositioning and removal
 - Chest tube insertion, aspiration, repositioning and removal

- Bronchoscopic tissue sample for the purpose of bronchoalveolar lavage and endobronchial brushing
- Intraosseous needle insertion
- Subcutaneous electrode placement for interoperation and perinatal fetal monitoring

Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx. (e.g., ETT intubation, LMA insertion)

Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx

Administering a substance by injection or inhalation

- inhaled medications
- oxygen administration
- anesthetic and/or specialty gases
- invasive mechanical ventilation
- non-invasive positive pressure ventilation
- intravascular, intramuscular, intradermal and/or sub-cutaneous injections

Tracheostomy tubes change

Diagnostic ultrasound

B. Other TCLs I'm applying to have the following specific TCLs currently imposed on my Certificate of Registration modified:

PART 3 - BACKGROUND INFORMATION

Briefly describe your rationale for requesting to remove/modify your TCLs (e.g., new employer, new role).

SAMPLE LETTER OF SUPPORT FROM EMPLOYER

Members who apply for a change to terms, conditions and limitations imposed on their certificates of registration are asked (where applicable) to submit a letter of support from their employer(s). The following is a sample of the employer's letter of support.

Date

Registrar

CRTO

180 Dundas Street West, Suite 2103

Toronto, ON M5G 1Z8

Dear Registrar,

Re: NAME Application for Change to Terms, Conditions and Limitations

This letter is to support NAME's application for change to terms, conditions and limitations. NAME started their employment at OUR HOSPITAL on March 1, 2022. Since then, NAME has been practising (under supervision) as a Full-Time Respiratory Therapist (40 hours per week average).

Between March 1 and May 1, 2022, NAME had completed an eight-week orientation program. During the orientation, NAME was observed both in a **simulation setting** and a **clinical environment** (Wards, ICU, OR). Enclosed, please find the competency checklists and peer feedback forms.

In addition, in April 2022, NAME successfully passed certifications for Intubations and Arterial Line Insertions.

During the supervised practice, NAME has demonstrated a professional attitude and a high standard of patient care.

If you have questions or need additional information, please contact me at PHONE / EMAIL.

Regards,

Supervisor NAME, RRT

Clinical Coordinator and Professional Practice Leader

COMPETENCIES CHECKLIST TEMPLATE

MEMBER'S NAME:		
FACILITY / SITE:		
AUTHORIZED ACT: Performing a prescribed procedure below the dermis (Basic)		
PROCEDURE: Arterial Puncture		
Performance Criteria		
<ul style="list-style-type: none"> • Assess any relative contraindications for the procedure • Prepare any required equipment • Use appropriate PPE • Apply infection prevention and control procedures throughout the procedure • Perform modified Allen's test • Perform arterial puncture using the appropriate technique • Document procedure 		
ACTIVITY LOG		
DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
2.		
3.		
4.		
5.		
<input type="checkbox"/> A review of all organizational learning packages, policies and procedures has been completed.		
Evaluator signature: _____		
COMMENTS		

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Performing a prescribed procedure below the dermis (Basic)

PROCEDURE: Venous Puncture

Performance Criteria

- Assess any relative contraindications for the procedure
- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform venous puncture using the appropriate technique
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Performing a prescribed procedure below the dermis (Basic)

PROCEDURE: Capillary Puncture

Performance criteria

- Assess any relative contraindications for the procedure
- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform capillary puncture using the appropriate technique
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Performing a prescribed procedure below the dermis (Basic)

PROCEDURE: Insertion, suturing, aspiration, repositioning, manipulation and removal of an arterial cannula

Performance Criteria

- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform insertion, suturing, aspiration, repositioning or removal of the arterial cannula using the appropriate technique
- Document procedure

Please indicate the arterial cannula procedure performed:

(e.g., arterial line)

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
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2.		
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Performing a prescribed procedure below the dermis (Basic)

PROCEDURE: Insertion, suturing, aspiration, repositioning, manipulation and removal of a venous cannula

Performance Criteria

- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform insertion, suturing, aspiration, repositioning or removal of a venous cannula using the appropriate technique
- Document procedure

Please indicate the venous cannula procedure performed:

(e.g., peripheral IV, internal jugular vein cannulation)

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
2.		
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Performing a prescribed procedure below the dermis (Advanced)

PROCEDURE: Manipulation or repositioning of a cannula balloon

Performance Criteria

- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform the procedure according to the approved certification package
- Document procedure

Please indicate the procedure performed:

(e.g. pulmonary capillary wedge pressure (PCWP), intra-aortic balloon pump (IABP))

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
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5.		

A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

CRTO-approved certification package has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:		
FACILITY / SITE:		
AUTHORIZED ACT: Performing a prescribed procedure below the dermis (Advanced)		
PROCEDURE: Chest needle insertion, aspiration, repositioning and removal		
Performance Criteria		
<ul style="list-style-type: none"> • Prepare any required equipment • Use appropriate PPE • Apply infection prevention and control procedures throughout the procedure • Perform the procedure according to the approved certification package • Document procedure 		
ACTIVITY LOG		
DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
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<input type="checkbox"/> A review of all organizational learning packages, policies and procedures has been completed. Evaluator signature: _____		
<input type="checkbox"/> A CRTO-approved certification package has been completed. Evaluator signature: _____		
COMMENTS		

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Performing a prescribed procedure below the dermis (Advanced)

PROCEDURE: Bronchoscopic tissue sample for the purpose of bronchoalveolar lavage and endobronchial brushing

Performance Criteria

- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform the procedure according to the approved certification package
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
2.		
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4.		
5.		

A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

CRTO-approved certification package has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:		
FACILITY / SITE:		
AUTHORIZED ACT: Performing a prescribed procedure below the dermis (Advanced)		
PROCEDURE: Intraosseous needle insertion		
Performance Criteria		
<ul style="list-style-type: none"> • Prepare any required equipment • Use appropriate PPE • Apply infection prevention and control procedures throughout the procedure • Perform the procedure according to the approved certification package • Document procedure 		
ACTIVITY LOG		
DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
2.		
3.		
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5.		
<input type="checkbox"/> A review of all organizational learning packages, policies and procedures has been completed. Evaluator signature: _____		
<input type="checkbox"/> CRTO-approved certification package has been completed. Evaluator signature: _____		
COMMENTS		

MEMBER'S NAME:		
FACILITY / SITE:		
AUTHORIZED ACT: Performing a prescribed procedure below the dermis (Advanced)		
PROCEDURE: Subcutaneous electrode placement for interoperative and perinatal fetal monitoring		
Performance Criteria		
<ul style="list-style-type: none"> • Prepare any required equipment • Use appropriate PPE • Apply infection prevention and control procedures throughout the procedure • Perform the procedure according to the approved certification package • Document procedure 		
ACTIVITY LOG		
DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
2.		
3.		
4.		
5.		
<input type="checkbox"/> A review of all organizational learning packages, policies and procedures has been completed. Evaluator signature: _____		
<input type="checkbox"/> CRTO-approved certification package has been completed. Evaluator signature: _____		
COMMENTS		

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx

Examples: ETT intubation, LMA insertion

Performance Criteria

- Select and confirm the function of equipment for intubation
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform the procedure using the appropriate technique
- Document procedure

Examples: ETT intubation, and LMA insertion.

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
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2.		
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4.		
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx

Performance Criteria

- Select, assemble and verify the function of equipment including selecting the appropriate size of catheter and appropriate suction level
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform the procedure using the appropriate technique
- Document procedure



DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Administering a substance by injection or inhalation

PROCEDURE: Administering inhaled medications

Performance Criteria

- Assess the need for medication
- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform the procedure using the appropriate technique and monitor the patient's response
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Administering a substance by injection or inhalation

PROCEDURE: Administering anesthetic and/or specialty gases

Performance Criteria

- Assess the need for medication
- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform the procedure using the appropriate technique and monitor the patient's response
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Administering a substance by injection or inhalation

PROCEDURE: Invasive mechanical ventilation

Performance Criteria

- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Initiate and manage invasive ventilation
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Administering a substance by injection or inhalation

PROCEDURE: Non-invasive mechanical ventilation

Performance Criteria

- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Initiate and manage non-invasive ventilation
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
2.		
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Administering a substance by injection or inhalation

PROCEDURE: Intravascular, intramuscular, intradermal and/or sub-cutaneous injections

Performance Criteria

- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Perform the procedure using the appropriate technique and monitor the patient's response
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
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A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Administer therapeutic oxygen by inhalation

Performance Criteria

- Assess the need for oxygen
- Prepare any required equipment
- Use appropriate PPE
- Perform the procedure using the appropriate technique and monitor the patient's response
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(S)	Evaluator Signature(s) and Designation(s)
1.		
2.		
3.		
4.		
5.		

A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

CONTROLLED ACT: Tracheostomy tube changes

Performance Criteria

- Explain the procedure to the patient
- Select and use appropriate equipment in relation to the clinical situation
- Perform the procedure using the appropriate technique and monitor the patient's response
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(S)	Evaluator Signature(s) and Designation(s)
1.		
2.		
3.		
4.		
5.		

A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature: _____

COMMENTS

MEMBER'S NAME:

FACILITY / SITE:

AUTHORIZED ACT: Performing Diagnostic Ultrasound

PROCEDURE: Diagnostic Ultrasound for Procedural Guidance

Performance Criteria

- Prepare any required equipment
- Use appropriate PPE
- Apply infection prevention and control procedures throughout the procedure
- Properly apply the transducer to the area of interest
- Adjust function keys appropriately
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population(s)	Evaluator Signature(s) and Designation(s)
1.		
2.		
3.		
4.		
5.		

A review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature:

COMMENTS

