College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

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

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 be registered with terms, conditions, and/or limitations (TCLs). These TCLs may be enacted by regulation (e.g., Graduate Certificates) or by one of the CRTO's statutory committees.

This guide is intended for Members who are registered with **TCLs imposed by the Registration Committee**. 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 that an RT practice under supervision when the Member has been away from practice for an extended period of time and does not meet the CRTO's two-year currency requirement. In this case, the supervised practice condition ensures that the Member undergoes the appropriate retraining, monitoring, and assessment before practising 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 Registration Committee to remove or modify the TCLs (see section D). Examples of the TCLs that may be imposed by the Registration Committee are listed in Table 1 below.

CONTENT:

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

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.

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 *Regulated Health Professions Act, 1991* 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.

   In this case, the Member (under **general supervision***) may, for example,
   - 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

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 regulated health professional who is authorized to perform the controlled act.

   In this case, the Member will need **direct supervision***, to, for example:
   - 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

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 regulated health professional who is authorized to perform advanced prescribed procedures.

   In this case, the Member must be under **direct supervision*** to, for example, perform:
   - Manipulation or repositioning of a cannula balloon
   - Chest needle insertion, aspiration, reposition and removal
   - Chest tube insertion, aspiration, reposition 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

   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

5. The Member shall only perform a **tracheostomy tube change for a stoma that is more than 24 hours old**, to gain competence in that procedure, and only if performed under the **direct supervision** of a regulated health professional who is authorized to perform the controlled act.

6. The Member shall only perform a **tracheostomy tube change for a stoma that is less than 24 hours old**, to gain competence in that procedure, and only if performed under the **direct supervision** of a regulated health professional who is authorized to perform the controlled act.

7.	The Member shall **not delegate** a controlled act. The Member can NOT delegate any controlled acts to other individuals. Delegation is the transfer of legal authority to perform a controlled act to a person not authorized to perform that controlled act.
8.	The Member shall **not accept delegation** for any controlled act.

B. SUPERVISION

Some certificates of registration may be subject to a supervision condition. In most cases, 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.

*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 regulated health care professional who is authorized and competent to perform the controlled act.** For example, a respiratory therapist, physician or nurse practitioner may provide supervision to respiratory therapists registered with TCLs.

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 practising 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 the supervision. This may include providing proper monitoring and assessment.
- Reporting: The employer must report to the CRTO if for example:
    - The RRT was terminated for professional misconduct, incompetence or incapacity.
    - It appears that the RRT 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 registered with TCLs may apply to the Registration Committee to have the terms, conditions, and limitations removed or modified. For example, a Member (registered with the supervision condition) practising in a home care setting may request that they be allowed to administer a substance by inhalation (controlled act no. 4) without supervision. 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 11-30 in this guide);
- ☐ A completed Supervisor Signature Sheet (page 31 in this guide); and
- ☐ Additional supporting documentation may include learning/orientation package(s), 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 as sufficient proof of clinical competence, especially in relation to the controlled acts authorized to Respiratory Therapy.

Applications to change TCLs are considered by Panels of the Registration Committee. Panel decisions are issued in writing within four weeks of the review date.

After reviewing the application, the Panel 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 samples of Competency Checklists (see pages 11-30). The checklists outline the performance criteria that must be demonstrated under a number of procedures. Members applying for a change to TCLs and their employers may use these checklists as part of their submission to the CRTO.

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 an 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
- Sample letter of support from employer
- Sample TCL Competency Checklist(s)
- Evaluator Signature Template

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
180 Dundas Street West,
Suite 2103
Toronto, Ontario M5G 1Z8

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

College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

APPLICATION for Change to TERMS, CONDITIONS AND LIMITATIONS

CRTO Members registered with terms, conditions and limitations (TCLs) ordered by the Registration Committee 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 Registration Committee, I wish to apply to the Registration Committee 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, reposition and removal
- ☐ Chest tube insertion, aspiration, reposition 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**

OFFICE USE ONLY							RECEIVED DATE	REVIEW DATE	NOTES

- ☐ **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 for a stoma that is more than 24 hours old**
- ☐ **Tracheostomy tubes change for a stoma that is less than 24 hours old**

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).

PART 4 - SUPPORTING DOCUMENTATION

Please list all documents attached to your application (e.g., letter of support from employer/supervisor, copies of clinical competency checklist(s), and additional supporting documentation).

Part 5 - DECLARATION AND AUTHORIZATION

☐ I **declare certify** that the statements made by me in this application are complete and correct to the best of my knowledge and belief.

☐ **I hereby authorize** the sources referred to on this form to release to the College of Respiratory Therapists of Ontario all information about me in the possession of the source for the purpose of CRTO registration.

SIGNATURE _____ **DATE** _____

SUBMITTING YOUR APPLICATION

Mail: CRTO, 180 Dundas St. W. Ste. 2103 Toronto, ON M5G 1Z8

FAX: 416-591-7890 Email: questions@crto.on.ca

QUESTIONS: 416-591-7800 or toll free 1-800-261-0528, e: questions@crto.on.ca Web: www.crto.on.ca

SAMPLE LETTER OF SUPPORT FROM EMPLOYER

Members who apply for change to terms, conditions and limitations imposed on their certificates of registration are asked (where applicable) to submit a letter of support from their employers. 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 her 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 in a **clinical environment** (Wards, ICU, OR). Enclosed, please find the competency checklists and peer feedback forms.

In addition, in April 2022, NAME had 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

- 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 appropriate technique
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population	Evaluator Signature and Designation
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☐ Review of all organizational learning packages, policies and procedures has been completed

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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 appropriate technique
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population	Evaluator Signature and Designation
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☐ Review of all organizational learning packages, policies and procedures has been completed

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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 appropriate technique
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population	Evaluator Signature and Designation
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☐ Review of all organizational learning packages, policies and procedures has been completed

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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, reposition or removal of arterial cannula using appropriate technique
- Document procedure

Please indicate the arterial cannula procedure performed: (e.g., arterial line)

ACTIVITY LOG

DATE	Environment / Patient Population	Evaluator Signature and Designation
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☐ Review of all organizational learning packages, policies and procedures has been completed

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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, reposition or removal of a venous cannula using 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	Evaluator Signature and Designation
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☐ Review of all organizational learning packages, policies and procedures has been completed

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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	Evaluator Signature and Designation
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☐ Review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature:

☐ CRTO approved certification package has been completed.

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

MEMBER'S NAME:

FACILITY / SITE:

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

PROCEDURE: Chest needle insertion, aspiration, reposition and removal

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	Evaluator Signature and Designation
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Evaluator signature:

☐ CRTO approved certification package has been completed.

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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	Evaluator Signature and Designation
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☐ Review of all organizational learning packages, policies and procedures has been completed.

Evaluator signature:

☐ CRTO approved certification package has been completed.

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

MEMBER'S NAME:

FACILITY / SITE:

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

PROCEDURE: Intraosseous needle insertion

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	Evaluator Signature and Designation
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Evaluator signature:

☐ CRTO approved certification package has been completed.

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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

- 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	Evaluator Signature and Designation
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Evaluator signature:

☐ CRTO approved certification package has been completed.

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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

Examples: ETT intubation, LMA insertion.

ACTIVITY LOG

DATE	Environment / Patient Population	Evaluator Signature and Designation
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Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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 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 appropriate technique
- Document procedure

DATE	Environment / Patient Population	Evaluator Signature and Designation
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☐ Review of all organizational learning packages, policies and procedures has been completed

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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 appropriate technique and monitor patient's response
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population	Evaluator Signature and Designation
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Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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 appropriate technique and monitor patient's response
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population	Evaluator Signature and Designation
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Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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	Evaluator Signature and Designation
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☐ Review of all organizational learning packages, policies and procedures has been completed

Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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

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Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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 appropriate technique and monitor patient's response
- Document procedure

ACTIVITY LOG

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Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

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 appropriate technique and monitor patient's response
- Document procedure

ACTIVITY LOG

DATE	Environment / Patient Population	Evaluator Signature and Designation
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Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

MEMBER'S NAME:

FACILITY / SITE:

CONTROLLED ACT: Tracheostomy tube changes (stoma more than 24 hours old)

Performance Criteria

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

ACTIVITY LOG

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Evaluator signature:

COMMENTS

COMPETENCIES CHECKLIST TEMPLATE

MEMBER'S NAME:

FACILITY / SITE:

CONTROLLED ACT: Tracheostomy tube changes (stoma less than 24 hours old)

Performance Criteria

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

ACTIVITY LOG

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

☐ Review of all organizational learning packages, policies and procedures has been completed

Evaluator signature:

COMMENTS