



A Checklist of Key Cardio-Respiratory Interventions for Entry-Level Physical Therapy Students – Short Form

The objectives of the CR checklist are: (1) to ensure that PT students gain experience with essential clinical skills, attitudes, behaviours and clinical reasoning within CR in order to obtain the minimum entry-level cardio-respiratory competencies prior to graduation, (2) to provide clinical supervisors with guidance as to the practice settings and clinical situations in which competence may be assessed; and (3) to highlight for students, clinical instructors and facilities that any clinical setting has the potential to assist students in acquiring CR competencies.

IMPORTANT NOTICE TO STUDENTS

The checklist is a guide for tracking PT student CR experiences. The checklist should be used to guide/maximize a student's CR clinical experience. A student is unlikely to obtain exposure and/or clinical experience in all of the areas listed prior to graduation. The checklist is NOT meant to be used as an evaluation tool or a measure of a student's CR clinical competence.

Assessment Techniques

Cardiorespiratory History/Lab Results: *The student will demonstrate knowledge of relevant history and lab results such as those listed below and incorporate them into assessment and treatment planning, in keeping with the practices of the clinical setting.*

	Completed (✓)	Comments
1. Chart review		
2. Arterial Blood Gas interpretation		
3. Pulmonary Function Test interpretation		
4. Results of cardiac/pulmonary diagnostic tests		
5. Awareness of CR precautions/contraindications for treatment		
6. Collection of radiographic information		
7. Significant Blood work findings		
8. Pharmacological implications of medications taken		
Other:		

Subjective: *The student will demonstrate knowledge and/or use of a variety of subjective assessment tools such as those listed below, in keeping with the practices of the clinical setting.*

	Completed (✓)	Comments
1. CR complaints (e.g., SOB, orthopnea, cough, angina)		
2. Pain/discomfort (e.g., angina, surgical pain, MSK)		
3. Use of patient self-report measures (may include: VAS pain scale, Quality of Life measures, Borg Rating of Perceived Exertion)		
4. Patient history (with focus on respiratory issues such as smoking, activity history)		
5. Recent Activity History		
6. Other		



Objective: Inspection/Observation: <i>The student will demonstrate knowledge and/or use of a variety of objective assessment measures such as those listed below, in keeping with the practices of the clinical setting.</i>			
	Completed (✓)		Comments
1. Lines and Tubes (understand implications)			
2. Understand the implications of and Perform Vital Signs (e.g., HR, BP, SpO ₂ , RR, Temp)			
3. Fluid Balance (understand implications)			
4. Jugular venous pressure (distention), peripheries, abdomen; understand implications			
	Observed/ Discussed (✓)	Performed on Patient (✓)	Comments
1. Chest Assessment (IPPA)			
• Inspection (cyanosis, etc.)			
• Palpation (chest excursion, etc.)			
• Percussion (resonance)			
• Auscultation (e.g., breath sounds, adventitia)			
• Cough (effective, ineffective)			
• Sputum (colour, consistency)			
2. Mobilization (independent; with assistance or supervision)			
• Bed mobility			
• Transfers			
• Gait/Ambulatory status/Stairs			
3. Functional Capacity Measures may include: 6 MWT, self –paced walk, shuttle walk)			
4. Balance (sitting, standing, walking)			
5. Posture (affecting chest expansion)			
6. Strength/Endurance (sufficient for safe mobilization)			
7. Range of Motion (e.g., UE/thoracic ROM)			
Other:			



Analysis and Planning

The student will learn to collect and analyze assessment findings and apply these to the identification of goals and the development of treatment plans, in keeping with the practices of the clinical setting.

	Completed (✓)	Comments
1. Formulate and articulate evaluation findings		
2. Establish short and long-term patient-centered goals		
3. Develop effective treatment plans		

Treatment Techniques

The student will become knowledgeable about a number of treatment methods, but may only practice some. All students should endeavour to obtain practice with a variety of treatment techniques, in keeping with the practices of the clinical setting.

	Observed/ Discussed (✓)	Performed on Patient (✓)	Comments
1. Mobilization (e.g., bed mobility, transfers, walking, stairs, prescription of mobility devise)			
2. Safe management of tubes & lines			
3. Oxygen titration			
4. Improved ventilation/breathing exercises - may include: (Mobilization; Deep Breathing-TEE; Facilitated Breathing/Manual Techniques –rib springing , basal lifts; Volume Augmentation – sniffing and breath staking, etc.)			
5. Secretion mobilization - may include: (Mobilization; Active Cycle Breathing Technique/ Huffing; PD; Percussions – manual/mechanical; Vibrations; PEP/Flutter, etc.).			
6. Secretion clearance – may include: (Cough, huff, manually assisted cough; Suctioning – non-intubated; Suctioning – intubated; Tracheal /stoma cough assist; In-exsufflation.			
7. Managing dyspnea – may include: (Purse lip breathing, positioning for SOB, energy conservation, relaxation training, etc.)			
8. Implement Exercise Training. (Prescription of adapted programs for special CR populations; may include: aerobic exercise or resistance exercise prescription)			
9. Thoracic mobility (e.g., AROM, AAROM, PROM)			
Other:			



Complete the following to track your experiences: CR Patient Diagnoses seen on Placement (list)	Settings/CR Environments (list)

Clinical Instructor (CI): Please review the student checklist outlining the interventions completed **during this placement**. Please sign below if the items indicated by the student as completed, observed and/or performed *during this placement* are accurate.

1. _____
Clinical Instructor (signature) (date, placement)

2. _____
Clinical Instructor (signature) (date, placement)

3. _____
Clinical Instructor (signature) (date, placement)