CRMC INTERNSHIP FOR THE REGISTERED NURSE PRESCRIBER IN FAMILY MEDICINE

Learner Manual

Advanced Health Assessment • Clinical Reasoning • Safe Prescribing • Continuity of Care

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Controlled educational document — the current approved CST and applicable regulation always govern clinical practice.

Document control

Control	Approved wording
Document owner	CRMC RN Prescriber Internship Program
Authors	Dawid Karczewski, Tomasz Karczewski, Merjorie M. A. Pinero, Avni K. Patel
Clinical approval	Medical Director or designated clinical prescribing lead
Audience	RNs admitted to the CRMC Internship; approved preceptors and programme faculty
Purpose	To teach the CRMC clinical method, programme expectations, advanced assessment, safe prescribing, diagnostic follow-through, continuity and assessment requirements.
Review cycle	At least annually and sooner when legislation, CRNA standards, the Master CST Register, programme assessment policy or clinical governance changes.
Distribution	Learner edition. Restricted examiner scenarios, answer keys and detailed grading mitigations are maintained separately.

Purpose and limits of this manual

This manual teaches the learner how to prepare, assess, reason, communicate, use a clinical support tool, prescribe or order within authorization, follow results, preserve continuity, document, reflect and demonstrate competence. It does not itself grant RN prescribing authorization, expand the learner's individual competence, replace the current approved clinical support tool, or authorize a medication or investigation that is not clearly permitted by the current CST and the learner's practice permit. Alberta RN prescribing is a restricted activity authorized within a specific clinical practice setting and location, with employer support and approved clinical support tools. [1-5]

Whenever this manual, a lecture, an archived pathway, an examination item, an external reference, a local custom or a colleague's advice conflicts with legislation, CRNA standards, employer policy or the current approved CST, the higher authority governs. The learner must stop, consult, document the concern and avoid prescribing or ordering beyond the current authority.

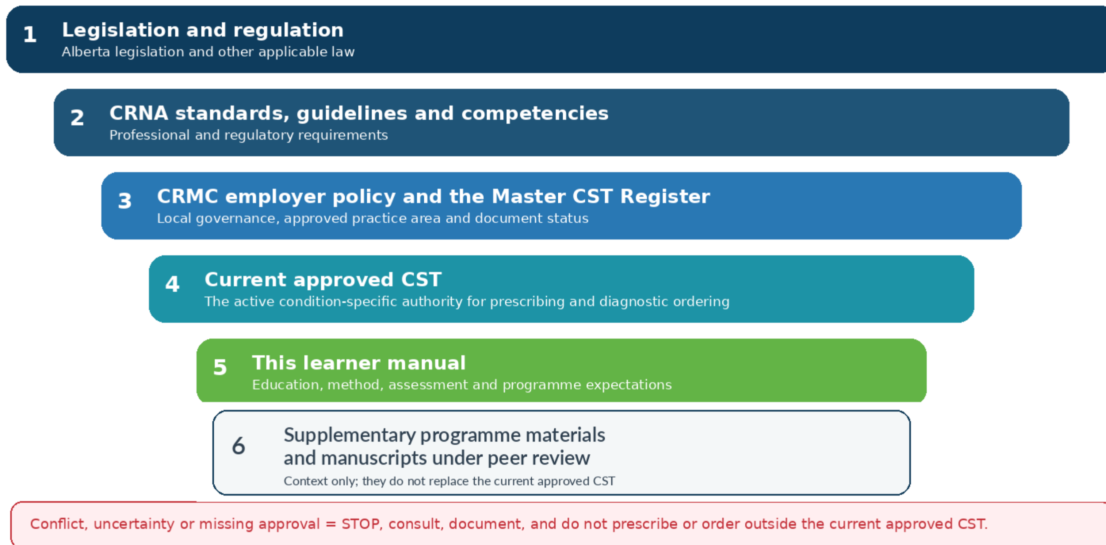

Figure 1. Clinical authority and document hierarchy used throughout the programme.

Document status legend

CURRENT CONTROLLED
Use at point of care only if listed as active in the Master CST Register.

LEARNER EDUCATION
Use for learning and assessment; it does not authorize prescribing.

SUPPLEMENTARY MATERIAL
Use for learning and context; it does not replace the current approved CST.

RESTRICTED EXAMINER
Maintain separately from the learner manual to protect assessment integrity.

Non-negotiable programme standards

- ☐ **Identity and safety first.** Confirm identity, consent, full vital signs, AVPU and MEWS or the applicable paediatric early-warning score before applying a quick-reference flowchart or CST.
- ☐ **Stable and predictable.** RN-prescriber management is limited to presentations that are stable, predictable, within the authorized clinical practice area and covered by the current CST.
- ☐ **Current CST only.** Use the version listed as active in the CRMC Master CST Register. Never alter, merge, localize or expand a CST without formal approval.
- ☐ **No off-CST prescribing.** Do not prescribe a medication or order a diagnostic test merely because it is familiar, recommended elsewhere or verbally suggested. It must be permitted by the current CST and within individual competence.
- ☐ **Teach-back.** Ask the patient or caregiver to explain the dosing, key precautions, adverse-effect plan and return instructions in their own words.
- ☐ **Results ownership.** The ordering RN remains responsible for tracking, reviewing, communicating and closing the loop on results unless a formal handover is accepted.
- ☐ Continuity message. After every patient encounter, send an internal EMR message or task to the patient's primary care provider (PCP).
- ☐ Escalate early. Use 911/EMS, ED/UCC, same-day consultation with a physician or nurse practitioner, or another appropriate pathway whenever instability, red flags, diagnostic uncertainty or a scope boundary is present.
- ☐ **Document the reasoning.** Record the assessment, red flags considered, working diagnosis, rationale, CST version, treatment, counselling, follow-up, results plan and communication.
- ☐ **Reflect and improve.** Record feedback, errors, near misses and learning needs in the portfolio; complete remediation before further entrustment when required.

DETAILED CLICKABLE CONTENTS
Click to open >

How to read this manual
Read Parts I-III at the beginning of the programme. Use Part IV during Advanced Health Assessment teaching. Use Parts V-VI during CST and clinical practice. Revisit Part VII before every formal assessment. Keep the appendices available at the point of learning, but use the current CST—not the appendix—as the clinical authority.

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PART I

Programme identity, rationale and governance

Why the programme exists, how it relates to regulation, and who is accountable for what.

1. Why this internship exists

Legal authorization to prescribe is not the same as readiness to manage family-medicine presentations safely. Prescribing requires more than selecting a medication: it depends on accurate history-taking, Advanced Health Assessment, diagnostic reasoning, pathophysiology, pharmacology, diagnostic stewardship, monitoring, safety-netting, documentation, consultation and follow-up. CRNA standards similarly position prescribing within assessment, judgment, employer supports, clinical support tools, team processes and continuity of care. [2-4]

The CRMC internship was created as an employer-based bridge between the minimum authorization pathway and competent day-to-day practice in family medicine. The publicly described programme is an 18-month, five-semester internship comprising 2,940 planned hours and staged exposure to CSTs, portfolio development, OSCEs, academic study and supervised patient care. [15]

Programme philosophy
The programme does not seek to create a “mini-NP.” It develops an RN prescriber who can manage defined stable presentations within a controlled practice area, recognize uncertainty and danger, collaborate effectively, preserve continuity, and prepare for possible later NP education without claiming NP equivalence.

2. Alberta, Aotearoa New Zealand and the CRMC bridge

Alberta authorizes eligible RNs to prescribe Schedule 1 drugs, except controlled drugs and substances, and order common diagnostic tests within a specific practice setting and location. Current CRNA application information includes active registration and good standing, at least 3,000 RN clinical practice hours, at least 750 hours in the practice setting/location, completion of the Athabasca University RN prescribing course, and employer support. [1-5]

Aotearoa New Zealand uses a postgraduate, practicum-based pathway for RN prescribers in primary health and specialty teams, including advanced assessment and diagnostic reasoning, prescribing sciences, an authorized-prescriber practicum, competency assessment and ongoing prescribing-related competence. Its postgraduate prescribing outcomes may be credited toward NP education. [18,39]

A CRMC policy-analysis manuscript under peer review proposes a hybrid model that combines Alberta’s enabling regulatory framework, New Zealand’s postgraduate and practicum logic, and CRMC’s family-medicine internship. The proposal is a policy model, not a tested outcome intervention. [17]

Dimension	Alberta current pathway	CRMC programme response
Authorization	Specific practice setting and location; employer support and CSTs required.	Teach site-specific practice while building a portable portfolio of competence evidence.
Education	Approved RN prescribing course plus required practice experience.	Add structured pathophysiology, pharmacology, Advanced Health Assessment, diagnostic reasoning and supervised clinical practice.

Dimension	Alberta current pathway	CRMC programme response
Clinical support	Employer policies, CSTs and collaborative relationships.	Use a centrally governed Master CST Register, preceptor approval, audit and version control.
NP bridge	Not formally credit-bearing or required for NP entry.	Develop graded responsibility and an evidence-rich portfolio without claiming NP status.
Continuing competence	CRNA continuing competence obligations apply.	Add monthly knowledge maintenance, portfolio reflection, CST review and practice audit.

3. Regulatory and professional foundation

- **Legislation.** The Health Professions Restricted Activity Regulation provides the legal foundation for authorized RN prescribing in Alberta. [1]
- **CRNA requirements and standards.** These define authorization, employer supports, professional accountabilities and practice expectations. [2]
- **CRNA guidelines.** These clarify clinical practice areas, CST requirements, diagnostic ordering and follow-up expectations. [3]
- **CRNA competencies.** These describe observable capabilities in assessment, diagnosis, prescribing, monitoring, communication and professional practice. [4]
- **Scope and competence.** The individual RN's practice is bounded by authorization, education, experience, current competence, patient needs, employer requirements and the practice environment. [6,7]
- **Documentation and coordination.** Clear, accurate documentation and effective team communication are core professional responsibilities. [8-10]

Authorization boundary
A CRMC certificate, internal entrustment decision, course result, preceptor endorsement or completed portfolio does not replace CRNA authorization. Conversely, CRNA authorization does not automatically establish competence in every CRMC CST.

4. Programme governance and roles

Role	Core accountability
CRMC programme leadership	Controls admissions, curriculum, programme standards, assessment, CST governance, final entrustment and certification.
Medical Director / clinical prescribing lead	Provides clinical governance, consultation infrastructure, patient-safety oversight and approval of local practice arrangements.
RN Prescriber Preceptor	Provides direct observation, coaching, feedback, chart review and workplace-based assessment within approved authority.
Primary care provider (physician or nurse practitioner)	Supports complex or outside-scope cases, supervises or consults as agreed, and participates in learning and patient-care escalation.
Community pharmacist	Supports medication selection, interactions, access, formulation and medication-safety questions within collaborative arrangements.
Clinical manager / programme coordinator	Coordinates schedules, records, competency logs, portfolio review, remediation, incidents and assessment logistics.

Role	Core accountability
Learner	Practises within authorization and competence, prepares before encounters, seeks help early, documents fully, closes result loops and maintains portfolio evidence.
Partner or satellite clinic	Maintains local employer supports, current CSTs, approved preceptors, privacy, EMR, follow-up, incident reporting and CRMC audit access.

5. Affiliated and satellite training sites

The CRMC Clinical Training Affiliation and Satellite Site Agreement uses a two-phase model. A Phase 1 Candidate Sponsor Site may nominate and support a learner but does not independently deliver the programme. A Phase 2 Satellite Training Site may host day-to-day training only after CRMC approval, Medical Director attestation, current site-specific RN-prescriber authorization, adoption of the CRMC CST package, site-readiness review, approved preceptors, centralized assessment and ongoing audit. [20]

- **One programme, multiple locations.** The programme remains centrally governed by CRMC.
- **No local CST stream.** Partner clinics may raise concerns but may not modify or substitute CRMC CSTs within the programme.
- **Site-specific authorization still applies.** A learner or preceptor must hold the required authorization for the specific practice area and location before prescribing there.
- **Clinical records remain local patient-care records.** Programme records, competency logs and audit information are managed according to privacy and governance requirements.
- **Calgary intensives and site visits may be required.** Individual Training Plans define location, supervision, assessments and costs.

PART II

The learner journey and staged competence

How the 18-month programme develops knowledge, judgment, skill and entrustment.

6. Programme map

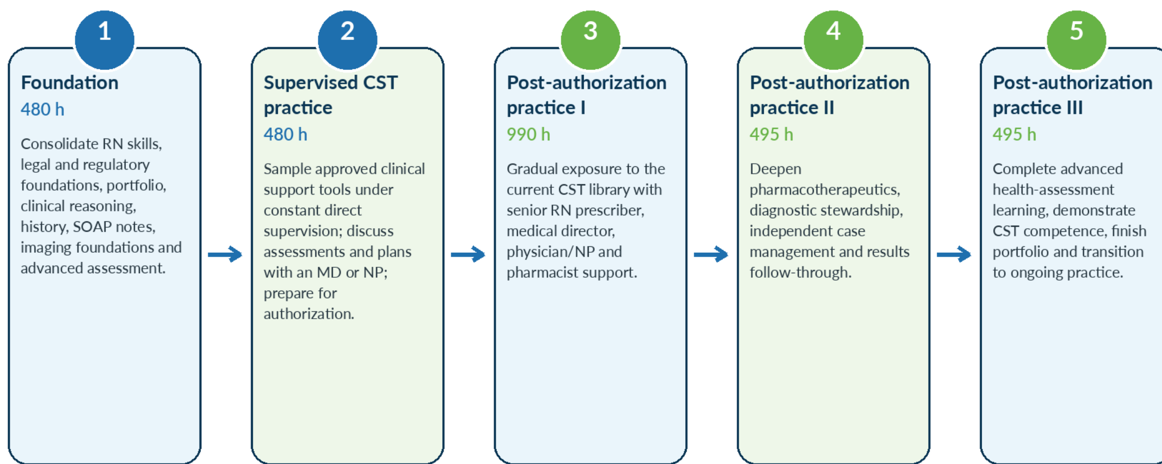

Figure 2. Proposed learner-facing map of the five-semester programme. The controlled programme schedule governs.

Stage	Planned hours	Primary focus	Illustrative theory
Semester 1 - Foundation	480	Consolidation of RN skills; regulatory foundations; portfolio; clinical reasoning; history; documentation; introductory Advanced Health Assessment.	RN prescribing education; anatomy and physiology; introductory pathophysiology and pharmacology.
Semester 2 - Supervised CST practice	480	Advanced RN-prescriber skills; supervised CST sampling; direct discussion of assessments and plans with MD/NP; authorization preparation.	Pathophysiology, pharmacology, radiology and applied case learning.

Stage	Planned hours	Primary focus	Illustrative theory
Semester 3 - Practice I	990	Post-authorization graded exposure to current CSTs with close support and chart review.	Pharmacotherapeutics and pathophysiology for advanced practice.
Semester 4 - Practice II	495	Increasing independence, diagnostic stewardship, result follow-through and interprofessional practice.	Advanced pharmacotherapeutics and pathophysiology.
Semester 5 - Practice III	495	Advanced Health Assessment consolidation, final entrustment, portfolio completion and transition.	Simulation and health-assessment learning.

Controlled schedule
The programme website, syllabi and internal documents have evolved over time. The learner's Individual Training Plan and current controlled syllabus determine the exact semester sequence, course names, hours and assessment dates.

7. Learning methods

- **Preparation before exposure.** Review assigned theory, current CST, key differential diagnoses, red flags and medication-safety issues before seeing a patient.
- **Observation.** Watch experienced clinicians conduct focused assessments, explain reasoning, use CSTs and communicate uncertainty.
- **Deliberate practice.** Repeat focused histories, physical examinations, calculations, prescriptions, requisitions and case presentations with feedback.
- **Direct patient care.** Progress from observation to direct supervision, immediate review, indirect supervision and CST-specific entrustment.
- **Case-based discussion.** Explain the problem representation, differential, dangerous alternatives, tests, treatment, safety net and follow-up.
- **Simulation and OSCE.** Practise standardized examinations and complete formal assessment of history, AHA, reasoning, prescribing and communication.
- **Reflective portfolio.** Record learning, feedback, mistakes, improvement actions and evidence of widening competence.
- **Monthly maintenance.** After programme completion, continue structured knowledge assessment and review of errors.

8. Staged entrustment

Competence is not inferred from attendance, licence, confidence, a single correct case or completion of a lecture. CRMC entrustment is CST-specific and requires repeated correct performance, professional conduct, safe escalation, reliable documentation and follow-through. The public programme description refers to correct use of a CST on at least three occasions without recurring assistance; the controlled competency framework determines the final standard. [15]

Level	Description	Typical supervision
0 - Not yet exposed	Learner has not completed prerequisites or observed the CST.	No independent patient management.
1 - Observation	Learner observes and explains the CST and expected workflow.	Preceptor leads the encounter.
2 - Direct supervision	Learner performs components while the preceptor is present and intervenes as needed.	Continuous direct observation.

Level	Description	Typical supervision
3 - Immediate review	Learner leads a stable case; assessment and plan are reviewed before implementation.	Preceptor readily available; plan reviewed before release.
4 - Indirect supervision	Learner manages eligible cases within current authorization and seeks help for defined triggers.	Preceptor available; routine retrospective review.
5 - Entrusted for current CST	Learner may use the CST independently at the approved site, with usual consultation and audit requirements.	Normal team support; periodic review and revalidation.

Entrustment can be reduced or withdrawn
Any change in authorization, competence, CST version, practice location, health status, incident pattern, supervision availability or patient population may require renewed direct supervision, remediation or suspension from a CST.

9. Portfolio and reflective practice

The portfolio provides evidence of the learner's academic and professional journey, current authorization, clinical exposure, feedback, reflection and competence development. CRMC's portfolio guidance recommends an updated CV, registrations, academic qualifications, specialization certificates, current BLS/ACLS and a dedicated reflective section. [16]

- ☐ Current CV and six-monthly update record
- ☐ CRNA permit, authorization documents and practice-area/location information
- ☐ Academic degrees, transcripts and programme certificates
- ☐ BLS, WHMIS and other required certifications
- ☐ Advanced Health Assessment competency records
- ☐ CST exposure and entrustment log
- ☐ Prescribing and diagnostic-ordering log using de-identified learning entries
- ☐ OSCE and workplace-based assessment results
- ☐ Case reflections, near misses, incidents and remediation evidence
- ☐ Professional-development plan and continuing-competence evidence
- ☐ Feedback from preceptors, MDs, NPs, pharmacists and other team members
- ☐ Quality-improvement or audit participation

PART III

The universal CRMC patient encounter

A single repeatable method before every CST-specific decision.

10. The CRMC clinical cycle

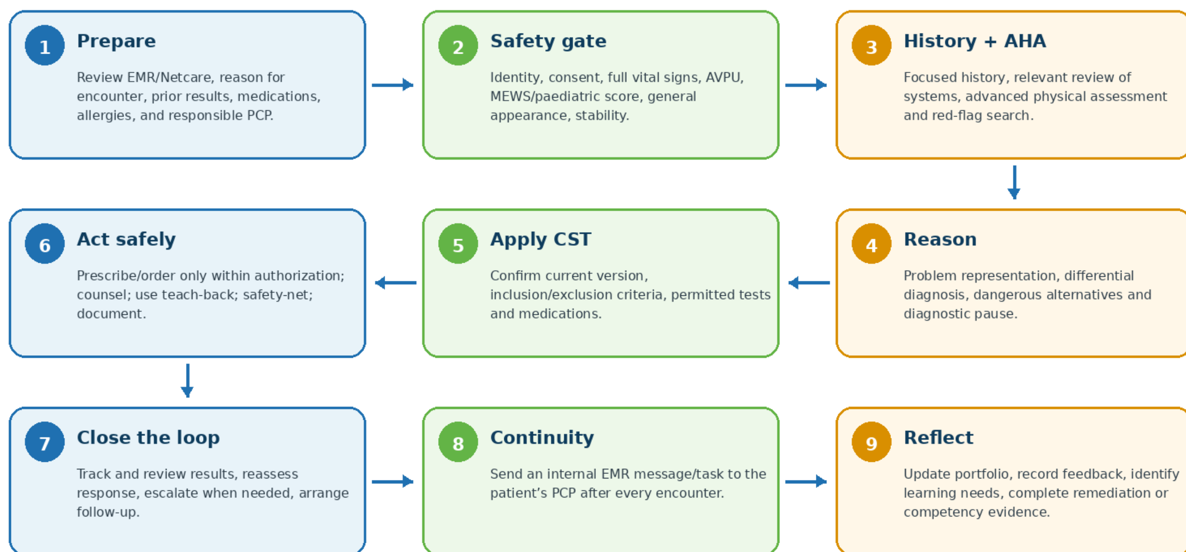

Figure 3. Universal encounter cycle. The sequence may overlap, but no step is omitted.

11. Prepare before the encounter

- ☐ Confirm the reason for contact and whether the patient is already in an emergency pathway.
- ☐ Review the patient's EMR and relevant Netcare information within privacy and role-based access rules.
- ☐ Identify the responsible PCP and any covering clinician.
- ☐ Review recent visits, active problems, allergies, medication list, recent antibiotics, pregnancy status, renal/hepatic information, prior cultures, laboratory results, imaging and treatment response.
- ☐ Confirm that a current approved CST exists and that the learner is authorized and competent to use it at this location.
- ☐ Prepare required equipment, PPE, forms, decision rules and patient-education material.
- ☐ Identify the supervising or consulting clinician and the escalation route before starting.

12. Universal safety gate and stability

The current 2026 CSTs supplied for this manual use a universal safety gate requiring a complete set of vital signs before the CST is applied: blood pressure, heart rate, respiratory rate, oxygen saturation, temperature, AVPU and MEWS. Paediatric patients require the age-appropriate early-warning approach specified by CRMC policy. [43-52]

Classification	Operational meaning
Stable	Physiologically stable; presentation is predictable; oral intake and follow-up are reliable; no immediate red flag; patient fits the CST inclusion criteria.
Unstable	Abnormal physiology, altered consciousness, respiratory distress, severe dehydration, shock, rapidly progressive illness, severe uncontrolled pain, or clinician concern for imminent deterioration.
Stable but outside scope	No emergency physiology, but the presentation is not covered by the current CST, remains diagnostically uncertain, requires a non-listed medication/test, or exceeds individual competence.

Never let a familiar diagnosis override instability
A patient may appear to have a common condition and still require emergency assessment. Stabilize and escalate first; diagnostic refinement and routine documentation come second.

13. Focused history and communication

A focused history is comprehensive enough to support the presenting problem, dangerous alternatives, medication safety and follow-up. It is not a rushed checklist. Use open questions first, then directed questions. Confirm the patient's own priorities and what they are most worried about.

- **Presenting concern.** Onset, location, duration, character, aggravating and relieving factors, radiation, timing, severity and functional effect.
- **Associated symptoms and red flags.** Ask the key negatives that distinguish the working diagnosis from dangerous alternatives.
- **Previous episodes.** Diagnosis, investigations, medication, response, complications and recurrence pattern.
- **Background.** Past medical and surgical history, pregnancy/lactation, immunocompromise, renal/hepatic disease and relevant family history.
- **Medication reconciliation.** Prescription, OTC, natural health products, adherence, recent changes and exact allergy/adverse-reaction history.
- **Social and contextual factors.** Occupation, smoking/substance use, sexual/reproductive history when relevant, housing, caregiving, access, cost, health literacy and ability to follow the plan.
- **Patient preference.** Discuss acceptable options, barriers and the patient's goals.

14. Advanced Health Assessment within the encounter

Advanced Health Assessment is taught through this programme as an applied clinical skill. The learner selects and performs the examination that is necessary to confirm or challenge the working diagnosis, identify red flags, support CST inclusion and determine whether escalation is required. The full system examination is learned in the skills programme; the patient encounter uses a focused examination with appropriate expansion when findings are atypical.

- Prepare, explain, obtain consent, ensure privacy, expose and drape appropriately.
- Use inspection, palpation, percussion and auscultation in the correct sequence for the body system.
- Compare bilaterally where relevant and document actual findings rather than "normal" without detail.
- Stop any manoeuvre that creates risk or is not appropriate to the presentation.

- Verbalize rationale during training and OSCEs; in practice, communicate clearly without turning the examination into a performance for the patient.
- Integrate general appearance and vital signs with focused findings.
- Know the limits of virtual care; arrange in-person assessment when the required examination cannot be performed reliably.

15. Clinical reasoning and the diagnostic pause

Clinical reasoning combines pattern recognition with slower analytical verification. Methodical history, examination, investigations, decision support, reflection and consultation help reduce the risk of premature closure and confirmation bias. The CMPA recommends obtaining sufficient clinical information, recognizing diagnostic uncertainty and "slowing down when you should." [12]

Diagnostic pause

- What is the one-sentence problem representation?
- What is the most likely diagnosis?
- What dangerous alternative could look similar?
- Which expected feature is missing or inconsistent?
- What finding would change the disposition?
- What is the patient-specific medication or investigation risk?
- Could I be wrong, and what is the safe next step if I am?

16. Presenting a case to a physician or nurse practitioner

Consultation is most useful when the learner presents a concise, organized clinical picture and a specific question. Do not ask another clinician to "just look" without first completing the assessment that is safe and within competence, unless immediate instability requires urgent takeover.

Element	What to communicate
Identity and reason	Age, relevant context and why the patient is being seen.
Stability	Vital signs, AVPU/MEWS, general appearance and immediate red flags.
Problem representation	A one-sentence summary with time course and key discriminating features.
Relevant findings	Important positives, negatives, medication/allergy/pregnancy/renal information and examination.
Assessment	Working diagnosis, differential and uncertainty.
Plan considered	CST, tests, medication, follow-up and safety net.
Consult question	The exact decision or assistance needed.
Read-back	Repeat and document the agreed plan, responsibility and follow-up.

17. Applying the current CST

1. Confirm the document name, version, effective date and active status in the Master CST Register.
2. Complete the universal safety gate and the minimum assessment specified in the CST.
3. Check inclusion criteria, exclusion criteria, patient group and any special pathway such as pregnancy or paediatrics.
4. **Identify ED/UCC red flags and same-day physician or nurse practitioner consultation triggers before choosing treatment.**
5. Confirm that each proposed investigation and medication is explicitly listed and appropriate for this patient.

6. Apply diagnostic and antimicrobial stewardship: order or prescribe only when the criteria are met and the action will change care.
7. Create the follow-up, results and after-hours plan before the patient leaves.
8. **Document the CST title/version, findings, rationale, prescription/order, counselling, safety net and PCP communication.**

A quick-reference flowchart does not replace the full CST
Quick-reference pages support recall after the full CST has been reviewed. They are not sufficient when the presentation is atypical, the patient has comorbidity, a contraindication is possible, or the learner is uncertain.

18. Safe prescribing

Medication safety requires correct indication, patient, drug, dose, route, frequency, duration, quantity, monitoring and follow-up. WHO identifies prescribing, transitions of care, polypharmacy and high-risk situations as key areas of medication harm. [14]

- ☐ Current indication and therapeutic goal are documented.
- ☐ Generic medication name is used unless an approved reason requires otherwise.
- ☐ Allergy and prior adverse reaction are clarified, not merely copied.
- ☐ Pregnancy, lactation, age, weight and paediatric maximum dose are considered.
- ☐ Renal and hepatic function are known or an evidence-based reason for not requiring them is documented.
- ☐ Current medications, recent antibiotics, duplicate therapy, interactions and contraindications are reviewed.
- ☐ The medication and complete posology are listed in the current CST for this patient group.
- ☐ Patient access, cost, formulation, ability to swallow/use device and adherence barriers are considered.
- ☐ Expected benefit, adverse effects, warning signs, monitoring and follow-up are explained.
- ☐ Prescription is complete, legible, dated, signed and linked to the clinical indication.
- ☐ Teach-back confirms understanding before release.

19. Diagnostic ordering and results ownership

The RN may order only tests clearly identified in the current CST. The CRNA guideline requires a process to avoid duplication, maintain accurate contact information, define who receives and reviews results, ensure interpretation and follow-up, and manage critical results after hours or during absence. [3]

Copying another clinician does not by itself transfer responsibility. The ordering clinician remains responsible unless a formal handover is accepted. CPSA's continuity standard similarly emphasizes tracking, timely review, patient notification, after-hours processes and formal acceptance of transfer. [11]

- ☐ Confirm the test has not already been ordered or completed.
- ☐ Document why the result will change diagnosis, medication selection, monitoring, disposition or follow-up.
- ☐ Use the correct requisition, indication and urgency; do not order in another clinician's name without a formal approved process.
- ☐ Confirm patient contact information and a backup method.
- ☐ Enter the expected result timeframe and tracking method.
- ☐ Arrange same-day review for STAT or high-risk results.
- ☐ Provide after-hours and absence coverage.
- ☐ Review and communicate the result; document successful and failed contact attempts.
- ☐ Adjust, narrow, stop or escalate treatment as permitted by the CST.
- ☐ Close the loop and send the required update to the patient's PCP.

20. Patient education, teach-back and safety-netting

Teach-back asks the patient or caregiver to explain the plan in their own words. It tests the clarity of the clinician's explanation rather than the patient's intelligence and supports engagement, safety and adherence. [13]

- **Diagnosis and uncertainty.** Explain what is known, what remains uncertain and why the plan is safe.
- **Medication.** Name, purpose, dose, route, timing, duration, missed-dose advice, common adverse effects and urgent warning signs.
- **Investigations.** Reason, where and when to complete, how results will be communicated and who is responsible.
- **Expected course.** When improvement should begin and what constitutes treatment failure.
- **Return precautions.** Specific symptoms that require 911, ED/UCC, same-day contact or routine follow-up.
- **Teach-back.** "I want to be sure I explained this clearly. Please tell me how you will take the medication and what you will do if…"
- **Show-me.** Use demonstration for inhalers, drops, topical treatment, devices or home monitoring where relevant.
- **Written reinforcement.** Provide approved paper, portal or after-visit instructions and document the material supplied.

21. Mandatory EMR continuity message after every encounter

	CRMC continuity standard After every patient encounter, the RN prescriber sends an internal EMR message or task to the patient's primary care provider (PCP). The message is required whether the encounter resulted in reassurance, a prescription, an investigation, a referral, an escalation or no definitive diagnosis.

The message preserves the patient's medical-home continuity and keeps the responsible PCP aware of episodic care. It does not remove the RN prescriber's responsibility for the encounter, prescription, ordered tests or follow-up. A direct call or face-to-face handover is additionally required when the result or plan is urgent, complex, unexpected or requires another clinician to act.

Message element	Minimum content
Subject line	RNP encounter — [date] — [working diagnosis/issue] — [urgency/action if any]
Encounter summary	Reason for contact, stability and key vital signs.
Assessment	Relevant history/examination, working diagnosis and CST used.
Action	Medication, diagnostic tests, referral, procedure or supportive care.
Safety and follow-up	Teach-back, red flags, follow-up date and result responsibility.
Action requested	State "for continuity/awareness only" or specify the exact action and timeframe requested from the PCP.

22. Documentation, outside-scope cases and escalation

Documentation is an integral component of care and must provide a clear, accurate and comprehensive account of the encounter. [8] Use SOAP or another approved CRMC template, but ensure that the note captures the clinical reasoning rather than only a list of findings.

- **Subjective.** Presenting concern, relevant history, red flags, medication/allergy and patient priorities.
- **Objective.** Vital signs, AVPU/MEWS, relevant Advanced Health Assessment and investigation results available at the time.
- **Assessment.** Problem representation, working diagnosis, differential, uncertainty and stability.
- **Plan. CST version, medication/test/referral, counselling, teach-back, safety net, follow-up, results ownership and PCP message.**

- **Outside scope.** Complete the assessment that is safe and within competence, stabilize if needed, consult or transfer appropriately, and do not prescribe/order outside the CST.
- **Verbal advice.** Document the name, role, time, question, advice, read-back, responsibility and follow-up. The authorized prescriber must own any order that is outside the RN's CST authority.
- **Refusal.** Document capacity considerations, information provided, risks discussed, alternatives, patient decision, witnesses and safety-net plan.

Do not turn another clinician's informal suggestion into an RN prescription outside the CST
If a required medication or test is not within the RN's current authority, an appropriately authorized prescriber must issue it, or a formally approved team process must be used. Documenting "as per PCP" does not create authority.

PART IV

Advanced Health Assessment

Systematic examination skills taught at the clinic and applied to focused family-medicine encounters.

23. General examination standards

The approved pass mark for the Advanced Health Assessment OSCE programme is 95%. Critical safety steps, correct technique, verbalized rationale, hand hygiene/PPE, role introduction, vital signs, bilateral comparison, appropriate exposure/draping and patient safety remain mandatory. [25-30]

- ☐ Explain the examination and obtain consent.
- ☐ Wash hands first; use PPE according to risk.
- ☐ Observe general appearance and vital signs.
- ☐ Position the patient and examination table correctly.
- ☐ Expose only what is necessary and maintain dignity.
- ☐ Use correct inspection, palpation, percussion and auscultation sequence.
- ☐ Compare sides when relevant.
- ☐ Identify normal and abnormal findings using precise descriptors.
- ☐ Verbalize rationale during teaching and OSCEs.
- ☐ Protect the patient from falls, pain, injury and inappropriate manoeuvres.
- ☐ Restore comfort, summarize findings and complete hand hygiene.

24. HEENT assessment

The HEENT curriculum includes inspection and palpation of the head and face; vision screening, pupils, extraocular movements and ophthalmoscopy; external ear, otoscopy and hearing tests; nasal and sinus assessment; oral cavity, pharynx and tonsils; TMJ; thyroid, trachea and cervical lymph nodes. [25]

- Always include visual acuity in red-eye presentations when feasible and escalate pain, photophobia, reduced vision, corneal findings or abnormal pupils.
- Inspect both ears, beginning with the less affected side, and describe the canal and tympanic membrane.
- Use precise throat and lymph-node findings rather than “red throat” or “LAD” alone.
- Recognize orbital, mastoid, deep-neck, airway and neurologic red flags.

HEENT examination guide

25. Cardiac and peripheral vascular assessment

The curriculum includes upper- and lower-extremity inspection, pulses, capillary refill, temperature, edema, varicosities, ulcers and lymph nodes; carotid examination; jugular venous pressure; precordial inspection and palpation; PMI; and systematic auscultation at the aortic, pulmonic, tricuspid and mitral areas. [26]

- Never palpate both carotids simultaneously.
- Characterize edema, pulse amplitude, asymmetry, skin changes and perfusion.
- Describe heart rate, rhythm, S1/S2, extra sounds and murmurs; do not over-interpret beyond competence.
- Escalate suspected ACS, shock, acute heart failure, limb ischemia, DVT/PE or neurovascular compromise.

Cardiac and peripheral vascular examination guide

26. Respiratory assessment

A complete respiratory assessment integrates work of breathing, respiratory rate, oxygen saturation, chest shape and symmetry, tracheal position, expansion, tactile findings where appropriate, percussion and systematic bilateral auscultation. The learner distinguishes normal breath sounds from crackles, wheeze, rhonchi, stridor, pleural rub and reduced air entry, while linking findings to stability and disposition.

- Observe before touching: speech, positioning, accessory muscles, cyanosis and fatigue may be more important than a single auscultatory finding.
- Compare equivalent areas side to side and include posterior lower lobes.
- Do not equate sputum colour alone with bacterial infection.
- Escalate hypoxia, severe work of breathing, altered mental status, silent chest, cyanosis or inability to maintain intake.

27. Abdominal assessment

The abdominal examination follows inspection, auscultation, percussion and palpation. The OSCE guide includes contour, skin, umbilicus, bowel sounds, bruits, general percussion, liver span, splenic assessment, light and deep palpation, masses and special techniques where indicated. [28]

- Auscultate before percussion and palpation.
- Observe for guarding, rigidity, rebound, pulsatile mass, distention, focal tenderness and systemic illness.
- Use validated scores only when appropriate and understand their limitations.
- Escalate suspected peritonitis, acute surgical abdomen, GI bleeding with instability, ectopic pregnancy, obstruction or severe pain.

Abdominal examination guide

28. Neurological assessment

The neurological curriculum includes mental status, cranial nerves, motor system, strength, tone, coordination, gait, sensory modalities, deep tendon reflexes, plantar response and meningeal signs. [27]

- Use BE-FAST or the current emergency neurological screen when stroke is possible; a single sudden focal deficit warrants emergency escalation.
- Compare sides and document the actual deficit, onset and last-known-well time.
- Differentiate a focused urgent screen from the full teaching examination.
- Escalate altered consciousness, new focal deficit, thunderclap headache, meningism, seizure with incomplete recovery or acute ataxia.

Neurological examination guide

29. Upper musculoskeletal assessment

The upper musculoskeletal guide covers cervical spine, shoulders, rotator cuff, elbows, wrists and hands. It uses inspection, palpation of landmarks, active range of motion, strength grading and selected special tests. [29]

- Document mechanism, hand dominance, function, deformity, swelling, neurovascular status and pain-limited movement.
- Do not force range of motion when fracture, dislocation or severe injury is possible.
- Use special tests selectively and interpret them within the total clinical picture.
- Escalate deformity, open injury, neurovascular compromise, compartment syndrome or high-risk trauma.

Upper musculoskeletal examination guide

30. Lower musculoskeletal assessment

The lower musculoskeletal guide covers spine, hips, knees, ankles and feet, including posture and gait, palpation, range of motion, strength, straight-leg raise, effusion tests, meniscal and ligament tests, ankle stability and Achilles testing. [30]

- Observe gait and ability to bear weight before detailed testing.
- Assess neurovascular status and examine the joint above and below when injury is suspected.

- Use Ottawa or other validated rules where the current CST permits.
- Escalate inability to bear weight with high-risk features, locked joint, acute loss of extension, fever/hot joint, deformity or neurovascular compromise.

Lower musculoskeletal examination guide

31. Skin, nail and dermoscopic assessment

- Describe morphology: macule, papule, plaque, vesicle, pustule, nodule, wheal, scale, crust, erosion, ulcer or fissure.
- Describe number, size, colour, border, symmetry, surface, distribution and evolution.
- Assess warmth, tenderness, fluctuance, drainage, lymphangitis and systemic features.
- Mark cellulitis margins when useful and arrange the CST-specified review.
- Use ABCDE and change/evolution for suspicious pigmented lesions; photograph only with consent and approved EMR process.
- Confirm fungal nail disease according to the current CST before prolonged or oral therapy.
- Escalate necrosis, pain out of proportion, rapidly progressive infection, mucosal involvement, severe drug eruption, orbital/hand/genital infection or systemic toxicity.

32. Imaging and ECG foundations

The programme includes chest and abdominal radiograph learning, recognition of normal structures and common abnormalities, and ECG foundations. The learner must distinguish recognition of an urgent abnormality from definitive specialist interpretation. Order only tests allowed by the current CST and communicate uncertain or unexpected results promptly.

- Use a consistent image-review sequence and confirm patient, date, view and technical quality.
- Correlate images with the clinical assessment; never treat the image in isolation.
- Use STAT only when the clinical question and follow-up process justify it.
- Abnormal, urgent or unexpected results require documented review, patient communication and appropriate consultation/escalation.
- ECG findings do not rule out ACS when the clinical presentation remains concerning.

PART V

Clinical learning modules and CST governance

How disease knowledge is organized without turning the learner manual into an uncontrolled prescribing book.

33. Standard format for every clinical module

1. Clinical purpose and learner outcomes.
2. Relevant anatomy, physiology and pathophysiology.
3. Typical presentation and epidemiologic context.
4. Dangerous alternatives and red flags.
5. Focused history and Advanced Health Assessment.
6. Diagnostic criteria, decision rules and permitted investigations.
7. Current CST inclusion, exclusion and escalation criteria.
8. Medication-selection reasoning, contraindications and monitoring.
9. Patient education, teach-back and safety-netting.
10. **Results ownership, follow-up and PCP continuity message.**
11. Documentation example and case presentation.
12. Practice cases, reflection prompts and competency sign-off.

Medication lists, doses, contraindications and diagnostic-test permissions change. They belong in the current controlled CST. The manual teaches how to use them safely and provides learning context; it does not create a parallel formulary.

34. System-based curriculum map

Unit	System / theme	Core learning topics
1	Dermatology	Histophysiology and skin assessment; dermatitis, psoriasis, rosacea, urticaria; nevi and skin cancer; bacterial, viral and fungal infections.
2	HEENT	Ear inspection and syringing; otitis media; sinusitis; tonsillitis; vertigo and vestibular disorders; glaucoma; COVID-19 HEENT manifestations.
3	Musculoskeletal	Rheumatoid arthritis; osteoarthritis; injury assessment; upper and lower MSK examination.
4	Anti-infectives	Antibacterial, antiviral and antifungal principles; stewardship; resistance; allergy and adverse-effect review.

Unit	System / theme	Core learning topics
5	Polypharmacy	Medication reconciliation, deprescribing principles, older adults, interactions and patient goals.
6	Neurology	Cranial nerves; pain pathways; Parkinson disease; headache; epilepsy; BPPV manoeuvres; HINTS+ foundations; motor neurone disease.
7	Respiratory	Respiratory pathophysiology; blood gases; asthma concepts; respiratory examination; radiography.
8	Genitourinary/renal	UTI; antimicrobial choices; kidney basics; nephrotic/nephritic syndromes; AKI; hyponatraemia.
9	Cardiovascular	Physiology; hypertension; heart failure; cor pulmonale; atherosclerosis; peripheral arterial disease; varicose veins.
10	Haematology	Blood components, haematopoiesis, haemostasis, laboratory interpretation and antithrombotic drugs.
11	Gastroenterology	GI pathophysiology; IBD; appendicitis; pancreatitis; cholecystitis; abdominal assessment and imaging.
12	Endocrinology/stress	Endocrine system; DKA; diabetes medications; thyroid disease; stress physiology.
13	Women's health	Reproductive physiology; menstrual cycle; endometriosis; menopause; contraception and pregnancy safety.
14	Men's health	Male reproductive health, prostate assessment concepts, PSA and urinary presentations.
15	Population/community health	Obesity and weight gain; risk factors; BMI limitations; prevention, behaviour change and referral.
16	Virology/vaccinology	Viral illness, immunization principles, public-health advice and treatment windows.
Additional	Mental health and advanced practice notes	Antidepressants, antipsychotics, lithium; cross-system adult advanced-practice notes; OSCE preparation.

35. Current controlled CST catalogue

The current controlled CST catalogue is listed below. The Master CST Register governs version, effective date and implementation status. Learners must use the active version at the point of care.

Current controlled CST catalogue		
Acne	Allergy (Rhinitis & Skin)	Canker Sore
Chlamydia/Gonorrhea/PID	Conjunctivitis & Stye	Diaper Dermatitis
Diverticulosis	Dysmenorrhoea	Eczema
Erectile Dysfunction	GERD	Gout
Headache / Migraine	Herpes Simplex Labialis	Hormonal Contraceptive
HTN Emergency	Influenza/COVID-19/Croup	Insect Bite
Long COVID-19	Musculoskeletal Pain	Obesity
Onychomycosis	Oral Candida	Osgod-Schlatter Disease
Otitis Media	Pneumonia (Community)	Post-Op Discharge
Psoriasis	Renewal of HTN or ADs	Shingles
Sinusitis & Strep Throat	Skin Bacterial Infection	Tinea Corporis
Tinea Pedis	Tobacco Cessation	Urinary Tract Infection

36. Supplementary programme materials

Supplementary programme materials provide context for learning, governance, assessment and service design. They support the learner's understanding of why the programme operates as it does, but they do not replace the current approved CST, applicable regulation, employer policy or individual professional judgment.

- Policy analyses and peer-review manuscripts explain programme rationale and service design.
- Affiliation agreements, programme policies and the Master CST Register govern delivery across participating sites.
- OSCE station materials, examiner resources and assessment policies support standardized assessment.
- Portfolio guidance, lectures, videos and clinical-skills resources support learner development.
- None of these resources replaces the current approved CST, applicable regulation or individual professional judgment.

Supporting-material rule
Educational and contextual material may support learning, but clinical decisions must follow the current approved CST, applicable regulation and employer policy.

PART VI

Triage, treatment, continuity and team practice

How the RN prescriber adds urgent-access capacity while keeping patients connected to their medical home.

37. Triage-Treatment-Continuity model

The CRMC model begins with emergency recognition by the medical office assistant, then RN-prescriber stability assessment, traffic-light urgency classification, appropriate booking, CST-guided assessment and treatment, safety-netting, results follow-through and EMR communication with the patient's PCP. A service-evaluation manuscript under peer review reports 5,032 pathway contacts during a 12-month period, but correctly treats potential ED/UCC diversion as a scenario rather than a confirmed outcome. [19]

Triage is not the endpoint
The RN prescriber does not merely redirect. For eligible stable patients, the pathway moves from triage to assessment, diagnosis, investigation, treatment, follow-up and continuity within the patient's clinic.

38. Emergency recognition and traffic-light booking

Step	Responsibility	Action
Immediate emergency screen	MOA or first contact	Recognize suspected MI, stroke or uncontrolled bleeding and activate the local emergency response; do not diagnose.
Stability assessment	RN prescriber	Use clinical assessment, vital signs and early-warning score to classify stable versus unstable.
Code Red	RN prescriber / booking team	Stable but urgent: same-day assessment. This is an operational primary-care category, not an ED triage level.
Code Yellow	RN prescriber / booking team	Semi-urgent: assessment within 24-48 hours, with contingency and safety-net plan.
Code Green	Booking team / PCP	Non-urgent: PCP appointment within the current policy timeframe.
No capacity	Team	Document variance, provide safe disposition and do not leave the patient without advice or escalation.

39. Collaboration, consultation and handover

Collaboration is not a substitute for individual accountability. The learner should seek input early when the diagnosis is uncertain, a red flag may be present, a listed treatment is unsafe, a test result is unexpected, follow-up cannot be ensured or the case is outside the CST. CRNA guidance emphasizes consultative supports, referral processes, team communication and continuity. [2,9,10]

Relationship	Meaning
Consultation	The RN retains the case and seeks advice on a defined question.
Shared management	Responsibilities are explicitly divided and documented.
Transfer of care	Another clinician formally accepts responsibility; the handover is documented.
Emergency transfer	EMS/ED assumes urgent care after safe handover; document the patient’s condition and information provided.
Notification only	The PCP is informed for continuity, but the RN remains responsible for the encounter and ordered follow-up.

40. Routine EMR continuity message example

Routine notification example
Hi there,
Your patient attended the RN-led clinic today. When you have a moment available, please, have a look at the notes from today to see if you would like to get in touch with the patient or if you're ok with the current plan.
Thanks.

PART VII

Assessment, progression and remediation

Assessment protects patients, guides learning and establishes CST-specific entrustment.

41. Theory and unit assessments

The programme uses regular theory assessment to reinforce pathophysiology, pharmacology, assessment and clinical reasoning. The learner should not study merely to recognize a multiple-choice answer. Each error becomes a learning task: locate the current authority, explain the reasoning, identify the clinical consequence and document the correction in the portfolio.

- Complete assigned modules and readings by the stated date.
- Use current resources and reconcile older lecture material with current CSTs.
- Review incorrect answers until the underlying concept is understood.
- Complete a reflective entry when required.
- Escalate disputed or clinically unsafe examination content to programme leadership rather than memorizing it.
- Do not share controlled questions, answer keys or assessment materials.

42. Six-month integrated OSCE

The six-month OSCE uses ten 15-minute family-medicine stations. Candidate-facing station tags require a focused history, relevant physical examination, diagnostic tool or CST use when appropriate, working diagnosis, prescribing or investigations within scope, and review of the plan with the patient. [22,23]

Detailed standardized-patient prompts, examiner answers and “grave mistake” mitigations are restricted examiner materials and are not reproduced in the learner manual. [24]

- Prepare for method, not memorized scenarios.
- Always complete the safety gate, PQRST/history framework, allergy check and relevant red-flag search.
- Perform the focused examination with correct technique.
- Use the current diagnostic tool/CST rather than an outdated answer key.
- Explain the plan and use teach-back.
- Arrange results and follow-up before closing the station.
- Recognize when current guidance requires escalation even if an older training scenario suggested otherwise.

Approved six-month OSCE standard
The pass mark for the six-month integrated OSCE is 95%. Learners must also meet all station-specific critical safety requirements and comply with the approved examiner instructions.

43. Advanced Health Assessment OSCEs

System-based Advanced Health Assessment OSCEs cover HEENT, cardiac/peripheral vascular, neurological, abdominal, upper musculoskeletal and lower musculoskeletal examinations. The approved pass mark is 95%, and all critical safety requirements and examiner criteria must be met. [25-30]

- Five minutes of preparation and fifteen minutes of examination are used in the supplied guides.
- Critical safety, positioning, exposure/draping and bilateral-comparison requirements must be met.
- The learner should practise both the complete system examination and the focused version used in real encounters.
- Passing a skills OSCE does not independently authorize use of a CST or a diagnostic conclusion.

44. Workplace-based assessment

Method	What is assessed	Evidence
Direct observation	History, AHA, communication, professionalism and safety.	Observation form and narrative feedback.
Case-based discussion	Reasoning, differential, CST choice, prescribing, tests and follow-up.	Structured case discussion.
Chart audit	Documentation, red flags, rationale, continuity message and closure.	De-identified audit record.
Prescription audit	Indication, drug/dose/duration, contraindications and counselling.	Prescription review log.
Results audit	Tracking, timely review, patient contact, action and closure.	Result-closure audit.
Multisource feedback	Reliability, teamwork, consultation and professional conduct.	Feedback from RNP/MD/NP/pharmacist/team.
Portfolio review	Learning trajectory, reflection and competence evidence.	Scheduled review and action plan.

45. Monthly post-completion assessment and continuing competence

The current monthly examination form supplied for this project contains 200 questions, allocates five hours, states a 90% pass mark, encourages progression to 100%, and requires review and reflection on incorrect answers. [21] The controlled assessment policy should govern future revisions and ensure every item remains consistent with current legislation, evidence, policy and CSTs.

- Sit the assessment at the required frequency and under the required conditions.
- Record score and topics requiring review.
- Complete targeted reading and a reflective entry for errors.
- Repeat or remediate according to current policy.
- Escalate repeated difficulty, unsafe reasoning or declining performance to the clinical manager/preceptor.
- Combine examination results with practice audit; a high test score alone does not establish clinical competence.

46. Remediation and unsuccessful performance

1. Protect patients: pause the affected CST, skill or level of independence where necessary.
2. Describe the specific gap using observed behaviour, not a global label.
3. Identify contributing knowledge, skill, communication, professionalism, system or wellbeing factors.
4. Create a written remediation plan with learning resources, supervised practice, timeframe and success criteria.
5. Reassess using a method matched to the gap: observation, OSCE, case discussion, chart audit or written assessment.
6. Document the outcome and any ongoing condition on entrustment.
7. Escalate fitness-to-practise, integrity, repeated unsafe practice or regulatory concerns through the appropriate process.

PART VIII

Quality, safety and transition to practice

Professional conduct, incident learning, audit and the move from learner to accountable prescriber.

47. Professionalism, privacy and culturally safe care

- Practise within authorization and competence; identify yourself accurately as an RN or RN prescriber.
- Use respectful, inclusive and trauma-informed communication.
- Use qualified interpretation and document language/access needs.
- Protect privacy when accessing EMR/Netcare, photographing lesions, discussing cases and maintaining portfolio evidence.
- Use de-identified learning records whenever identifiable information is not necessary.
- Maintain professional boundaries and avoid conflicts of interest, coercion or misleading claims about the programme.
- Address discriminatory or unsafe practice and create psychological safety for learners and team members to speak up.
- Recognize fatigue, stress, illness or impairment that may affect judgment and seek support before patient safety is compromised.

48. Incident and near-miss learning

Incidents and near misses are learning opportunities and governance signals. Report them promptly according to CRMC and site policy. Serious patient-safety events, unauthorized prescribing, missed critical results, privacy breaches, CST deviations or regulatory complaints require immediate escalation. [20]

- ☐ Medication error or near miss
- ☐ Incorrect or superseded CST used
- ☐ Unauthorized medication/test or practice location
- ☐ Delayed or missed result review
- ☐ Failure to contact or safety-net patient
- ☐ Failure to send the required PCP continuity message
- ☐ Delayed emergency escalation
- ☐ Privacy or documentation breach
- ☐ Professional conduct or fitness-to-practise concern
- ☐ Assessment integrity concern

Just culture with accountability
Focus first on immediate patient protection, transparent disclosure through the appropriate process, system contributors and corrective action. A learning culture does not excuse deliberate, reckless or dishonest behaviour.

49. Audit and quality improvement

- Prescribing indication, selection and duration audit
- Antibiotic stewardship and culture-directed adjustment
- Diagnostic-test indication and duplication audit
- Result tracking, critical results and closure audit

- 48-72-hour or CST-specific follow-up compliance
- PCP continuity-message compliance
- CST version and documentation audit
- Patient refusal, complaint and incident trends
- OSCE and monthly assessment item review against current CSTs
- Equity, access, interpretation and patient-experience review

Quality data should improve systems and learning. Research publication or patient-level linkage requires separate privacy, governance and ethics consideration.

50. Transition to authorized practice and ongoing development

- ☐ CRNA authorization is current for the specific practice area and location.
- ☐ Practice permit, prescriber ID/PracID and employer/provider registrations are verified.
- ☐ Current Master CST Register and local policies are accessible.
- ☐ EMR templates, prescription and requisition processes are tested.
- ☐ Consultation, after-hours and result-coverage arrangements are documented.
- ☐ Initial CSTs and level of entrustment are explicitly defined.
- ☐ Early charts, prescriptions and results are reviewed according to transition plan.
- ☐ Portfolio, continuing competence, monthly assessment and audit schedule are active.
- ☐ Any move to another location triggers the required CRNA and employer process; competence evidence does not by itself transfer authorization.

Completion is the beginning of accountable practice
The graduate should know more, perform more reliably and recognize limits earlier than at entry. Safe practice continues to depend on current evidence, deliberate reflection, consultation, audit and willingness to stop when the presentation no longer fits.

PART APPENDICES

Learner checklists, templates and controlled-resource map

Print or use electronically. Adapt only through approved document-control processes.

Appendix A. Universal patient-encounter checklist

- ☐ Identity, role, consent and reason for encounter confirmed.
- ☐ EMR/Netcare, medications, allergies, pregnancy status, relevant history/results and responsible PCP reviewed.
- ☐ Full vital signs, AVPU and MEWS/paediatric score documented.
- ☐ Stable versus unstable decision made; red flags explicitly checked.
- ☐ Focused history and relevant Advanced Health Assessment completed.
- ☐ Problem representation, working diagnosis, differential and dangerous alternative considered.
- ☐ Current CST name/version and inclusion/exclusion criteria confirmed.
- ☐ Only permitted tests/medications selected; contraindications and interactions reviewed.
- ☐ Patient education, teach-back and safety-netting completed.
- ☐ Follow-up and results ownership arranged before discharge.
- ☐ Complete note entered.
- ☐ Internal PCP EMR message/task sent.
- ☐ Portfolio/competency log updated when required.

Appendix B. Prescription safety checklist

- ☐ Correct patient and indication
- ☐ Current CST authorizes this medication for this patient group
- ☐ Generic name, strength and dosage form
- ☐ Route, dose, frequency, duration and quantity
- ☐ No uncontrolled duplicate or recent failed therapy
- ☐ Allergy and adverse-reaction history
- ☐ Renal/hepatic function and required adjustment
- ☐ Pregnancy/lactation, age/weight and paediatric maximum
- ☐ Interactions, contraindications and high-risk conditions
- ☐ Patient access, cost and formulation
- ☐ Monitoring, expected response and follow-up
- ☐ Adverse effects and urgent warning signs
- ☐ Teach-back documented
- ☐ PCP continuity message sent

Appendix C. Diagnostic order and result-closure checklist

- ☐ Current CST authorizes the test

- ☐ Test is not duplicated
- ☐ Clinical question and management consequence documented
- ☐ Correct urgency, site and preparation
- ☐ Patient contact and backup contact confirmed
- ☐ Expected result date and tracking method recorded
- ☐ After-hours/absence coverage confirmed
- ☐ Result reviewed and interpreted within competence
- ☐ Patient notified; failed attempts documented
- ☐ Action taken or consultation arranged
- ☐ Formal handover accepted if responsibility transferred
- ☐ PCP notified and result loop closed

Appendix D. EMR continuity-message template

Field	Template
Subject	RNP encounter — [date] — [issue/working diagnosis] — [routine/urgent]
Reason and stability	[Reason] | BP __ HR __ RR __ SpO_2 __ T __ AVPU __ MEWS __
Assessment	[Key history/exam] | Working diagnosis/differential | CST name/version
Action	[Medication/test/referral/supportive care]
Education	Teach-back completed: yes/no | Key safety-net instructions
Follow-up/results	[RNP/covering clinician] will review by [date/time]
Request	For awareness only / please review [specific issue] by [time]
Escalation	[If applicable: direct call/EMS/ED/UCC handover details]

Appendix E. SOAP note template

Section	Required content
S — Subjective	Presenting concern; PQRST/OLDCARTS; associated symptoms; red flags; relevant ROS; prior episodes/treatment; PMH/PSH; medications/OTC/NHP; allergies/reaction; pregnancy/lactation; social/context; patient goals.
O — Objective	General appearance; full vital signs; AVPU/MEWS; focused Advanced Health Assessment; relevant point-of-care or available results.
A — Assessment	Problem representation; working diagnosis; differential; dangerous alternative considered; stable/predictable decision; CST inclusion and uncertainty.
P — Plan	CST name/version; medication/test/referral; counselling and teach-back; safety net; follow-up and results responsibility; consultation/handover; PCP EMR message.

Appendix F. Case-presentation template

"This is a [age/context] patient seen for [problem]. They are [stable/unstable] with vital signs/MEWS [...]. The problem began [...] and is characterized by [...]. Important positives are [...]; important negatives/red flags are [...]. Relevant history, medications, allergies, pregnancy/renal/hepatic factors are [...]. Examination shows [...]. My working diagnosis is [...] with differential [...]. I used/considered [CST/version]. I propose [...]. My specific question is [...]."

Appendix G. Reflective entry template

Prompt	Learner response
Encounter or learning event	De-identified description and context.
What I noticed	Key findings, emotions, assumptions and decisions.
Reasoning	How I formed and tested the working diagnosis.
Feedback or outcome	What the preceptor, patient, result or follow-up revealed.
Gap or risk	Knowledge, skill, communication, system or professional issue.
Learning action	Resource, practice, supervision or policy review.
Evidence of change	How and when improvement will be demonstrated.
CST/governance implication	Whether an exam item, CST or workflow concern should be reported.

Appendix H. CST entrustment record

Field	Record
Learner	
CST name/version	
Prerequisite theory completed	
Cases observed	
Cases under direct supervision	
Cases with immediate review	
Cases under indirect supervision	
Prescriptions/orders audited	
Results loops audited	
Recurring assistance or error pattern	
Remediation completed	
Recommended entrustment level	
Preceptor name/signature/date	
Programme decision/review date	

Appendix I. OSCE learner guide

- Use the reading time to identify the task, patient group, time-critical risks and required examination.
- Begin with identity, role, consent, hand hygiene and stability.
- Use a structured history; do not omit the questions that distinguish red flags.
- Perform the relevant examination in a safe, patient-centred sequence.
- State the working diagnosis and the dangerous alternative you excluded.
- Use the current CST/decision tool and check allergies and contraindications.
- Explain the plan in plain language and use teach-back.
- Arrange results and follow-up; close with safety-netting.
- Do not memorize outdated answer keys that conflict with current CSTs.
- Exact station scenarios, standardized-patient prompts and examiner mitigations are restricted.

Appendix J. Detailed learning-material map

J1. Regulatory, reasoning and professional foundations

- CRNA Scope of Practice for Registered Nurses
- CRNA Entry-Level Competencies and CCRNR entry-level competencies
- CRNA RN-prescribing competencies, requirements/standards and guidelines
- RN portfolio and reflective journal
- Clinical reasoning and diagnostic decision-making
- Taking a patient clinical history
- Writing SOAP notes: theory and video
- Interpreting chest radiographs
- Calgary Black Book
- Overcoming examination anxiety
- Presenting a clinical case to a physician or nurse practitioner

J2. Physical examination learning

- HEENT
- Cardiac and peripheral vascular
- Respiratory
- Neurological
- Abdominal
- Upper musculoskeletal
- Lower musculoskeletal
- OSCE demonstration and preparation
- Dermoscopy master class
- Visual acuity using the Snellen chart
- Evaluating red flags

J3. Radiology learning

- Chest radiograph: normal film, mediastinum and heart, lung fields, collapse/consolidation, nodules and masses
- Abdominal radiograph: normal film, intraluminal gas, extraluminal gas, calcification, iatrogenic/accidental/incidental objects

J4. Pathophysiology and pharmacology units

Dermatology

- Histophysiology and assessment
- Dermatitis, psoriasis, rosacea and urticaria
- Moles and skin cancers
- Bacterial, viral and fungal skin infection

HEENT

- Ear inspection and syringing
- Otitis media
- Sinusitis and tonsillitis
- Otosclerosis
- Vertigo, labyrinthitis, Ménière disease and vestibular neuritis
- Semicircular canals/BPPV
- Glaucoma
- HEENT manifestations of COVID-19

Musculoskeletal

- Rheumatoid arthritis
- Osteoarthritis

Anti-infectives

- Anti-infectives parts 1-3

Polypharmacy

- Deprescribing and outcome improvement

Neurology

- Cranial nerves
- Pain physiology/pathways
- Parkinson disease
- Headache
- Epilepsy and antiepileptics
- BPPV manoeuvres
- HINTS+
- Motor neurone disease

Respiratory

- Respiratory pathophysiology
- Arterial blood gases
- Asthma concepts

Genitourinary/renal

- UTIs and antimicrobial therapy
- Kidney basics
- Nephrotic/nephritic syndromes
- AKI
- Hyponatraemia

Cardiovascular

- Cardiovascular physiology
- Hypertension
- Heart failure
- Cor pulmonale
- Atherosclerosis
- Peripheral arterial disease
- Varicose veins

Haematology

- Blood components, haematopoiesis, haemostasis and clot dissolution
- Haematologic pathophysiology
- Laboratory interpretation
- Antithrombotic drugs

Gastroenterology

- GI pathophysiology
- IBD

- Appendicitis
- Pancreatitis
- Cholecystitis

Endocrinology/stress

- Endocrine system
- DKA
- Diabetes pharmacology
- Hypothyroidism
- Hyperthyroidism
- Stress pathophysiology

Women's health

- Reproductive physiology
- Menstrual cycle
- Endometriosis
- Menopause

Men's health

- Men's health series
- PSA

Population/community health

- Obesity and weight gain

Virology/vaccinology

- Vaccinology

Mental health

- Antidepressants
- Antipsychotics

Appendix K. Master CST Register template

CST name	Version	Effective date	Status	Implementation confirmed	Review date
			Active / suspended / retired		
			Active / suspended / retired		
			Active / suspended / retired		
			Active / suspended / retired		
			Active / suspended / retired		
			Active / suspended / retired		
			Active / suspended / retired		
			Active / suspended / retired		

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End of learner manual

Questions, CST concerns, suspected errors or suggestions for improvement should be submitted through the current CRMC programme and CST governance process. Do not wait for the next scheduled review when a patient-safety concern is identified.