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| **REGISTRE DE SUIVI DE FORMATION, DE SUPERVISION ET D’AUTORISATION**  **ACTIVITÉS DE SOINS CONFIÉES AUX AIDES-SOIGNANTS** – **ADMINISTRATION DES MÉDICAMENTS** | | | | | | | | | | | | | | | | |
| **Nom et prénom de l’aide-soignant : Formation réglementée complétée le (date) :**  Préciser le type de formation reçue :  Centre de services scolaire (CSS)  CISSS ou CIUSSS  Entreprises d’économie sociale en aide à domicile (EESAD) | | | | | | | | | | | | | | | | |
| **Voies d’administration** | | **Date** | **Initiales** | | **Voies d’administration** | | | **Date** | | **Initiales** | **Voies d’administration** | | | **Date** | **Initiales** | |
| **Directives : Les initiales sont celles du professionnel habilité qui remplit le registre pour chacune des voies d’administration confiées**  **Légende : S**  Supervision (date de la dernière supervision) **A**  Autorisation **R**  Révocation d’autorisation | | | | | | | | | | | | | | | | |
| Voie orale | S |  |  | | Voie ophtalmique | | S |  | |  | Voie rectale | | S |  |  | |
| A |  |  | | A |  | |  | A |  |  | |
| R |  |  | | R |  | |  | R |  |  | |
| Précision : | | | | | Précision : | | | | | | Précision : | | | | | |
| Voie topique | S |  |  | | Voie auriculaire | | S |  | |  | Par colostomie | | S |  |  | |
| A |  |  | | A |  | |  | A |  |  | |
| R |  |  | | R |  | |  | R |  |  | |
| Précision : | | | | | Précision : | | | | | | Précision : | | | | | |
| Voie transdermique (timbre cutané) | S |  |  | | Voie nasale | | S |  | |  | Voie vaginale | | S |  |  | |
| A |  |  | | A |  | |  | A |  |  | |
| R |  |  | | R |  | |  | R |  |  | |
| Précision : | | | | | Précision : | | | | | | Précision : | | | | | |
| Par inhalation | S |  |  | | Voie sous-cutanée (insuline seulement) | | S |  | |  | Autre  Entérale   Épipen   Glucagon | | S |  |  | |
| A |  |  | | A |  | |  | A |  |  | |
| R |  |  | | R |  | |  | R |  |  | |
| Précision : | | | | | Précision : | | | | | | Précision : | | | | | |
| **SIGNATURE DU PROFESSIONNEL** | | | | **PROFESSION** | | **INITIALES** | | | **SIGNATURE DU PROFESSIONNEL** | | | **PROFESSION** | | | | **INITIALES** |
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| **RÉVOCATION D’UNE AUTORISATION** |
| **Nom et prénom de l’aide-soignant :** |
| **Mesures exigées (reprise d’une formation, supervision requise ou autre)**  **Signature du professionnel habilité : Titre d’emploi : Date :** |
| **Suivis effectués**  **Signature du professionnel habilité : Titre d’emploi : Date :** |
| **Préautorisation de l’aide-soignant**   Orale Date : Initiales :  Topique Date : Initiales :   Transdermique Date : Initiales :  Inhalation Date : Initiales :   Rectale Date : Initiales :  Colostomie Date : Initiales :   Nasale Date : Initiales :  Ophtalmique Date : Initiales :   Auriculaire Date : Initiales :  Sous-cutanée Date : Initiales :   Vaginale Date : Initiales :  Entérale Date : Initiales : |

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| **SIGNATURE DU PROFESSIONNEL** | **PROFESSION** | **INITIALES** | **SIGNATURE DU PROFESSIONNEL** | **PROFESSION** | **INITIALES** |
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| **REGISTRE DE SUIVI DE FORMATION, DE SUPERVISION ET D’AUTORISATION**  **Activités de soins confiées aux aides-soignants – Soins invasifs d’assistance aux activités de la vie quotidienne (AVQ)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nom et prénom de l’aide-soignant :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Formation réglementée complétée le (date) :**  Préciser le type de formation reçue :  Centre de services scolaire (CSS)  Établissement  Entreprises d’économie sociale en aide à domicile (EESAD) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Activités de soins** | | | | | | **Date** | | | | | **Initiales** | | | **Activités de soins** | | | | | | | | | **Date** | | | | | **Initiales** | | | **Activités de soins** | | | | | | | | | **Date** | | | **Initiales** | | | |
| **Directives : Les initiales sont celles du professionnel habilité qui remplit le registre pour chacune des activités de soins invasifs confiées.**  **Légende : F**  Formation complémentaire **S**  Supervision **A**  Autorisation **R**  Révocation de l’autorisation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Stimulation réflexe anal | | | F | | |  | | | | |  | | | Toucher rectal | | | | | | | F | |  | | | | |  | | | Curage rectal | | | | | | | F | |  | | |  | | | |
| S | | |  | | | | |  | | | S | |  | | | | |  | | | S | |  | | |  | | | |
| A | | |  | | | | |  | | | A | |  | | | | |  | | | A | |  | | |  | | | |
| R | | |  | | | | |  | | | R | |  | | | | |  | | | R | |  | | |  | | | |
| Précision : | | | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | |
| Insertion tube rectal | | | F | | |  | | | | |  | | | Dilatation stomie intestinale | | | | | | | F | |  | | | | |  | | | Irrigation par colostomie | | | | | | | F | |  | | |  | | | |
| S | | |  | | | | |  | | | S | |  | | | | |  | | | S | |  | | |  | | | |
| A | | |  | | | | |  | | | A | |  | | | | |  | | | A | |  | | |  | | | |
| R | | |  | | | | |  | | | R | |  | | | | |  | | | R | |  | | |  | | | |
| Précision : | | | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | |
| Cathétérisme intermittent chez l’homme | | | F | | |  | | | | |  | | | Cathétérisme intermittent chez la femme | | | | | | | F | |  | | | | |  | | | Irrigation vésicale circuit ouvert | | | | | | | F | |  | | |  | | | |
| S | | |  | | | | |  | | | S | |  | | | | |  | | | S | |  | | |  | | | |
| A | | |  | | | | |  | | | A | |  | | | | |  | | | A | |  | | |  | | | |
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| Précision : | | | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | |
| Autre : | | | F | | |  | | | | |  | | | Autre : | | | | | | | F | |  | | | | |  | | | Autre : | | | | | | | F | |  | | |  | | | |
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| **Nom et prénom de l’aide-soignant :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Activités de soins** | | | | **Date** | | | | | **Initiales** | | | | | **Activités de soins** | | | | | | | **Date** | | | | | **Initiales** | | | **Activités de soins** | | | | | | | | | **Date** | | | **Initiales** | | | | |
| **Directives : Les initiales sont celle du professionnel habilité qui remplit le registre pour chacune des activités de soins invasifs confiées.**  **Préciser, sous le nom de l’activité, le nom de l’usager pour lequel le soin invasif est autorisé.**  **Légende : F**  Formation complémentaire **S**  Supervision **A**  Autorisation **R**  Révocation de l’autorisation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Instillation trachéobronchique | F | | |  | | | | |  | | | Nettoyage canule interne et changement pansement | | | | | | | F | |  | | | | |  | | | Irrigation gastrostomie, jéjunostomie | | | | | | | F | |  | | |  | | | | |
| S | | |  | | | | |  | | | S | |  | | | | |  | | | S | |  | | |  | | | | |
| A | | |  | | | | |  | | | A | |  | | | | |  | | | A | |  | | |  | | | | |
| R | | |  | | | | |  | | | R | |  | | | | |  | | | R | |  | | |  | | | | |
| Précision : | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | | |
| Aspiration sécrétions nasales avec cathéter | F | | |  | | | | |  | | | Aspiration sécrétions trachéobronchiques | | | | | | | F | |  | | | | |  | | | Irrigation tube nasogastrique ou autre | | | | | | | F | |  | | |  | | | | |
| S | | |  | | | | |  | | | S | |  | | | | |  | | | S | |  | | |  | | | | |
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| Précision : | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | | |
| Gonflement/dégonfle-ment ballonnet canule trachéostomie | F | | |  | | | | |  | | | Alimentation entérale ou par tube | | | | | | | F | |  | | | | |  | | | Autre : | | | | | | | F | |  | | |  | | | | |
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| R | | |  | | | | |  | | | R | |  | | | | |  | | | R | |  | | |  | | | | |
| Précision : | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | | | Précision : | | | | | | | | | | | | | | | | |
| **Mesures exigées lors d’un retrait d’une autorisation (reprise d’une formation, supervision requise ou autre) et suivi effectué**  **Signature du professionnel : Titre d’emploi : Date :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE DU PROFESSIONNEL** | | | | | | | | | | | **PROFESSION** | | | | | | **INITIALES** | | | | | | | **SIGNATURE DU PROFESSIONNEL** | | | | | | | | | | | **PROFESSION** | | | | | | | | **INITIALES** | | |
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| **REGISTRE DES AIDES-SOIGNANTS AUTORISÉS À ADMINISTRER DES MÉDICAMENTS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nom du lieu (RPA, ressource, installation ou autre) : Nom du responsable du lieu :** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **VOIE D’ADMINISTRATION DES MÉDICAMENTS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **INSCRIRE LA DATE D’AUTORISATION (A) ET LES INITIALES (I) DU RESPONSABLE DU LIEU POUR CHAQUE VOIE D’ADMINISTRATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nom de l’aide-soignant** | | | | | | | | | | | Orale | | | | Topique | | | | Transdermique | | | Ophtalmique | | | | | | | Auriculaire | | | Nasale | | | Rectale | | Entérale | | | | Vaginale | | | Inhalation | | | | | Insuline SC | |
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| **SIGNATURE** | | | | | | **INITIALES** | | | | | **SIGNATURE** | | | | | | | | **INITIALES** | | | | | | | **SIGNATURE** | | | | | | | | | **INITIALES** | | **SIGNATURE** | | | | | | | | | | **INITIALES** | | |
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| **REGISTRE DES AIDES-SOIGNANTS AUTORISÉS À ADMINISTRER DES MÉDICAMENTS** | | | | | | | | | | | | | | | | | | | | | |
| **Nom du lieu (RPA, ressource, autre) : Nom du responsable du lieu :** | | | | | | | | | | | | | | | | | | | | | |
| **VOIE D’ADMINISTRATION DES MÉDICAMENTS** | | | | | | | | | | | | | | | | | | | | | |
| **INSCRIRE LA DATE D’AUTORISATION (A) ET LES INITIALES (I) DU RESPONSABLE DU RESPONSABLE QUI REMPLIT LE FORMULAIRE** | | | | | | | | | | | | | | | | | | | | | |
| **Nom de l’aide-soignant** | | | | Orale | | Topique | Transdermique | | Ophtalmique | | Auriculaire | Nasale | Rectale | | Entérale | | Vaginale | Inhalation | Insuline SC | | |
|  | | | **A** |  | |  |  | |  | |  |  |  | |  | |  |  |  | | |
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| **SIGNATURE** | **INITIALES** | | | **SIGNATURE** | | | **INITIALES** | | **SIGNATURE** | | | | **INITIALES** | | **SIGNATURE** | | | | **INITIALES** |
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| **REGISTRE DES AIDES-SOIGNANTS AUTORISÉS À EFFECTUER DES SOINS INVASIFS** | | | | | | | | | | | | | | | | | | |
| **Nom du lieu (RPA, ressource, autre) : Nom du responsable du lieu :** | | | | | | | | | | | | | | | | | | |
| **ACTIVITÉS DE SOINS INVASIFS CONFIÉES** | | | | | | | | | | | | | | | | | | |
| **INSCRIRE LA DATE D’AUTORISATION (A) ET LES INITIALES (I) DU RESPONSABLE DU RESPONSABLE QUI REMPLIT LE FORMULAIRE** | | | | | | | | | | | | | | | | | | |
| **Noms des aides-soignants autorisés** | | | | **Élimination intestinale et vésicale** | | | | | | | **Alimentation** | | | | | **Précisions** | | |
|  Curage rectal   Toucher rectal   Stimulation anale | |  Cathétérisme intermittent |  Irrigation par colostomie   Irrigation vésicale | | Autre : | | Alimentation entérale   Tube nasogastrique   Gastrostomie   Autre : | Irrigation   Tube nasogastrique   Gastrostomie   Autre : | | | Autre : |
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| **REGISTRE DES AIDES-SOIGNANTS AUTORISÉS À EFFECTUER DES SOINS INVASIFS** | | | | | | | | | | | | | | | | | |
| **Nom du lieu (RPA, ressource, autre) : Nom du responsable :** | | | | | | | | | | | | | | | | | |
| **ACTIVITÉS DE SOINS INVASIFS CONFIÉES** | | | | | | | | | | | | | | | | | |
| **INSCRIRE LA DATE D’AUTORISATION (A) ET LES INITIALES (I) DU RESPONSABLE QUI REMPLIT LE FORMULAIRE** | | | | | | | | | | | | | | | | | |
| **Noms des aides-soignants autorisés** | | | | **Soins respiratoires** | | | | | | | **Autres** | | | | | **Précisions** | |
|  Aspiration des sécrétions trachéobronchiques   Instillation trachéobronchique | | Nettoyage canule interne de la trachéostomie et changement de pansement | | Gonflement et dégonflement du ballonnet de la trachéostomie | | Aspiration des sécrétions nasales avec cathéter |  | |  | |  |
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