



CLINICAL COMPETENCY

COMPETENCY TITLE:	CPAPos
APPROVED BY MEDICAL DIRECTOR:	<i>[Signature]</i>
APPROVED BY OPERATIONS MANAGER:	<i>[Signature]</i>
DATE APPROVED:	7/2/2010

EMPLOYEE NAME / NUMBER:	
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PROCEDURE:	<input type="checkbox"/> Employee demonstrates understanding that the CPAP circuit must be the circuit provided by Physicians Ambulance. <input type="checkbox"/> Employee demonstrates understanding and use of the 3 sizes of CPAP masks. <input type="checkbox"/> Employee demonstrates understanding that the CPAPos must utilize the facemask provided in our bag. <input type="checkbox"/> Employee demonstrates the understanding of the indications of CPAP. <input type="checkbox"/> Employee demonstrates the understanding of the contraindications of CPAP. <input type="checkbox"/> Employee demonstrates the need to discuss treatment with patient prior to application of mask. (Verbal Sedation) <input type="checkbox"/> Employee demonstrates proper assembly of CPAP circuit and connection to oxygen source. <input type="checkbox"/> Employee demonstrates the knowledge of the method of giving a breathing treatment while on CPAPos. <input type="checkbox"/> Employee demonstrates the use of appropriate oxygen connections.
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CRITICAL FAILURE:	<input type="checkbox"/> Failure to check for hypotension, or any other contraindication prior to Initiating CPAP. <input type="checkbox"/> Addition of CPAP above the 10 cmH2o.
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OPERATIONAL NOTES:	<input type="checkbox"/> We cannot utilize the CPAPos on trach patients. <input type="checkbox"/> Indications and Contraindications are from EMS Protocol. <input type="checkbox"/> Per Protocol 10cmH2o is the maximum pressure. <input type="checkbox"/> Used for failed oxygenation and CHF patients. <input type="checkbox"/> Mask seal is Critical .
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I hereby certify that the below named employee demonstrated competency in the CPAPos, without infractions of any critical criteria.

Certified By	
Signature / Date	

My signature below indicates that I have read and understood all of the above information provided to me regarding the CPAPos. I am aware that I may seek retraining at anytime I wish.

Signature / Date	
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