CPAP Application Checklist
All BLS Agencies:

____Signed Letter of Intent

____CPAP Agreement

____Required Agency Information Sheet

____Regional Medical Director Statement of Agreement

____Signed Statement of Agreement from Medical Director DOH 4362

____Standard Operating Guidelines for use of CPAP

CPAP Required Agency Information *(please print)*

Agency Name: _____
Agency Phone Number: _____
Agency Mailing Address: _____
_____

1. Designated representative responsible for the CPAP Administration Program:
Name: _____
Daytime Phone #: _____
Email (if applicable): _____

2. Agency Designated Administrator:
Name: _____
Daytime Phone #: _____
Email (if applicable): _____

3. Agency Medical Advisor:
Name: _____
Daytime Phone #: _____
Email (if applicable): _____

4. Agency QI Coordinator:
Name: _____
Daytime Phone #: _____
Email (if applicable): _____

5. Type of CPAP Unit: _____

Medical Director Statement of Agreement

I hereby agree to serve as the Medical Director for:

_____.
(*name of agency*)

I understand that all patient care will be provided under my license, in accordance with the NYS and North Country REMAC regional protocols and training guidelines, except in cases of gross negligence resulting in injury or death. *Upon signing this document, I agree to:*

- Provide and/or assist with annual CPAP in-services/updates and training
- Annually renew the CPAP agreement with this agency
- Participate in Q.I., and review all calls in which CPAP was utilized and any other calls as necessary
- Provide medical leadership
- Act as a resource for continuing education
- Remain familiar with regional and NY State and BLS protocols

MD signature: _____

MD name printed: _____

Date: _____ MD daytime phone #: _____

MD address: _____

_____

AGENCY: _____
SECTION: Additional Patient Care Therapies
SUBJECT: Continuous Positive Airway Pressure (CPAP)
DATE: _____

Purpose:
To enable (Place department name here) NYS credentialed Basic Life Support EMS providers to utilize CPAP for patients > 10 y/o who meet criteria as outlined by NYS DOH training curriculum and protocol. This is in accordance with New York State Department of Health Bureau of EMS (NYS DOH BEMS) Policy Statement 15-02

Education/Credentialing:
All Basic Life Support EMS providers are required to attend training that includes a didactic presentation and skills evaluation. Additional training should be completed on application of specific device utilized by agency according to manufacturer recommendations. The initial training must be conducted by a NYS Critical Care or Paramedic CIC. Annual agency training will occur on CPAP. Training documentation will be retained by the agency in the provider's training files.

Quality Control:
Routinely, EMT's will inspect the CPAP device for damage, replace if appropriate and document. CPAP use will be documented on the patient care report in accordance with standard medical practice.

Oversight:
The agency CQI Committee with oversight by the Agency Medical Director will perform quality assurance evaluations on each CPAP administration for the initial six months of the program, or longer at the request of the Agency Medical Director. After this initial program review, the CQI Committee and Agency Medical Director must review CPAP use on a regular basis at a minimum annually. This includes submission of quality review sheet to NCEMS.

Storage:
Store in such a way to prevent damage of unit

Safety:
The EMS vehicle will provide a safe disposal for medical waste/sharps on the vehicle.

Required Amount:
Two (2) CPAP units- Minimally 1 should be on ambulance (preferably in portable bag), second can be in cabinet on ambulance.

CPAP Unit being utilized _____

Approved 9/21/15 AMS