RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

ADMINISTRATIVE POLICY AND PROCEDURE

Subject: BASIC VENTILATOR COMPETENCY **Policy No.:** A243.2

Supersedes:	April 11, 2010	Review Date:	March 23, 2023
Origin Date:	October 20, 2006	Revision Date:	

PURPOSE:
To ensure that specified personnel working unsupervised with a patient on a ventilator have and maintain a basic level of competency as outlined in the Basic Ventilator Competency Skills Checklist (Attachment I).

POLICY:
1. WHO is required to demonstrate competency?

   Demonstration of basic ventilator competency is required for the following inpatient and outpatient staff working unsupervised with patients on ventilators:
   - physical therapists
   - occupational therapists
   - recreation therapists
   - speech therapists
   - case managers
   - social workers
   - psychologists
   - certified occupational therapy assistants
   - physical therapist assistants
   - physician assistants
   - students/fellows affiliated with these respective disciplines

   Nursing competencies fall under the Department of Nursing Policy and Procedure #A540.

2. WHAT specific competencies are required?

   Staff will meet all competencies listed on the Basic Ventilator Competency Skills Checklist (Attachment I) that fall within their scope of practice. Staff members who do not meet the required competencies will require supervision by a competent staff member when working with a ventilator-dependent patient off the patient's unit.

3. WHEN are competency assessments conducted?

   Competency assessments will be conducted and documented annually for existing staff. Staff new to working with ventilator dependent patients is required to demonstrate competency prior to working unsupervised with ventilator dependent patients.

PROCEDURE:

Revised: 4/10
Reviewed: 4/10, 3/23

Approved By:

Each Department is responsible for compliance and documentation of ventilator competencies for their respective staff. This includes ensuring that the appropriate staff participates and that timely ongoing assessments are conducted and documented.

Documentation of competency compliance will be accomplished by completion of the Basic Ventilator Competency Skills Checklist (Attachment I). The checklist will be filed in the personnel folder of each staff member and maintained by the department.

The Respiratory Therapy Department will ensure a uniform competency assessment process by training a designated department trainer to administer the competency assessment to staff in their respective departments according to the discipline's scope of practice. Department trainers will be re-certified annually by the Respiratory Therapy Department. Documentation of certification and re-certification of department trainers will be maintained by the Respiratory Therapy Department.

ATTACHMENTS

Basic Ventilator Competency Skills Checklist
Pass Type I Criteria
Pass Type II Criteria
Pass Type III Criteria

Basic Ventilator Competency Skills Checklist

Employee Name: ____
Job Title: ____
Supervisor's Name: ____

Basic Ventilator Competency Criteria:
✓= meets criteria   – = does not meet criteria   **OS** = outside scope of practice

_____ Identifies the meaning of ventilator alarms and how to respond to each alarm
- High Pressure
- Low Pressure
- Apnea
- Vent Inop

_____ Demonstrates ability to provide respiratory assistance with the ambu bag
_____ Recognizes signs and symptoms of respiratory distress such as: cyanosis, diaphoresis, anxiety, or "clicking".
_____ Demonstrates ability to safely suction the ventilator-dependent patient (when within the individual clinician's scope of practice)
_____ Demonstrates/describes the steps to take when transferring a patient between bed and wheelchair
- Plans for the patient's transfer based on the patient's level of tolerance
- Explains the importance of connecting the remote ventilator alarm at the bedside

_____ Identifies the difference between the internal and external batteries and how to determine which is in use
_____ Verbalizes the need to ensure that the emergency bag is with the patient at all times and includes the appropriate supplies
_____ Explains the use of a speaking valve
_____ Describes the three types of pass criteria for a patient who is ventilator dependent
_____ Verbalizes an understanding that when ventilator-dependent patients are taken off grounds, they need to be accompanied by a nurse, respiratory therapist, or appropriately trained patient-designated caregiver (i.e., family member or significant other who has completed Pass Type II criteria - Attachment B)

COMPETENCY ASSESSMENT AND VERIFICATION (check one)

_____ Employee **MEETS** the basic ventilator competency requirements

_____ Employee **DOES NOT MEET** the basic ventilator competency requirements to work unsupervised with a ventilator-dependent patient and needs to be re-tested

_____ Above criteria **DO NOT APPLY** to this employee, since he/she will not work unsupervised with a ventilator-dependent patient

Employee Signature ____ Date: _____________

Instructor's Signature ____ Date: _____________

________**Certified** by the Department of Respiratory Therapy as a **Department Trainer** for Basic Ventilator Competency

Respiratory Therapy Instructor's Signature____________________________ Date: _____________

PASS TYPE I: Within JPI Building Only.

______________________________ Name of Patient

______________________________ Primary Nurse ________ Date

BLANK shows that caregiver has not met goals
NA means that goal does not apply at this time
SIGNATURE shows that caregiver has met goals

______________________________ R.T. Training Coordinator ________ Date

______________________________ Caregiver - Relationship ________ Date

RT	**DATE**	**SIGNATURE**
- Interpret Ventilator Alarm Systems		
- Check Ventilator circuit without cueing		
NURSING	**DATE**	**SIGNATURE**
- Appropriate use of the Ambu Bag without cueing 3		
- Suctioning techniques X2		
- Check emergency bag content without cueing		
- Ischial pressure relief when up in W/C without cueing X2		
- Caregiver informed that patient is not allowed to leave the unit unless with authorized staff until Pass 1 training completed		
PT	**DATE**	**SIGNATURE**
- Wheelchair safety		

I hereby acknowledge having undergone the above training, and I understand and hereby acknowledge receipt of the above information.

______________________________ Caregiver's Signature ________ Date

______________________________ Nursing Signature ________ Date

☐ Training Not Completed
Reason:

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER
County of Los Angeles Department of Health Services

CRITERIA FOR PASS FOR VENTILATOR DEPENDENT PATIENT TYPE I

Original To Be Placed In Medical Record
Copy To Be Provided To Caregiver

RD655 (N2-95)

NAME
RLAMC #
B.D., SEX

UNIT

Month-Day	Year	

County of Los Angeles Department of Health Services
Rancho Los Amigos National Rehabilitation Center

CRITERIA FOR PASS
VENTILATOR DEPENDENT PATIENT TYPE I

PT'S NAME

R#
DOB

PASS TYPE II: Within Rancho Grounds and/or Apollo Park. Must also have passed **Pass Type I** criteria

Name of Patient ______________________

Primary Nurse ______________________ Date ________

R.T. Training Coordinator ______________________ Date ________

Caregiver - Relationship ______________________ Date ________

BLANK shows that caregiver has not met goals
NA means that goal does not apply at this time
SIGNATURE shows that caregiver has met goals

RT	**DATE**	**SIGNATURE**
- Perform trach change with supervision of RT and/or MD X1		
- Checking effectiveness of vent under supervision of RT without cueing		
- 1. Check vent setting		
- 2. Check and troubleshoot ventilator circuit and cascade for tubing disconnects, obstructions and leaks.		
- 3. Clear the circuit		
- 4. Review alarms		
- 5. Review the 3 different power sources for ventilators		
- 6. Ventilator battery charge		
- 7. Oxygen delivery system		
PT	**DATE**	**SIGNATURE**
- Manual & power W/C mobility on ramps and rough terrain		
- Power W/C trouble shooting		
NURSING	**DATE**	**SIGNATURE**
Caregiver informed that patient is not allowed to leave the building unless with authorized staff until Pass II training completed.		

I hereby acknowledge having undergone the above training, and I understand and hereby acknowledge receipt of the above information.

Caregiver's Signature ______________________ Date ______________________

Nursing Signature ______________________ Date ______________________

☐ Training Not Completed
Reason:

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER
County of Los Angeles Department of Health Services

RD655 (N2-95)

CRITERIA FOR PASS FOR VENTILATOR DEPENDENT PATIENT TYPE II

Original To Be Placed In Medical Record
Copy To Be Provided To Caregiver

NAME
RLAMC #
B.D., SEX

UNIT

Month-Day	Year	

County of Los Angeles Department of Health Services
Rancho Los Amigos National Rehabilitation Center

CRITERIA FOR PASS
VENTILATOR DEPENDENT PATIENT TYPE II

PT'S NAME

R#
DOB

PASS TYPE III: Off Grounds or Practice Apartment must also have completed **Pass Type I & II** Criteria

______________________________ Name of Patient

______________________________ Primary Nurse ________ Date

______________________________ R.T. Training Coordinator ________ Date

______________________________ Caregiver - Relationship ________ Date

BLANK shows that caregiver has not met goals
NA means that goal does not apply at this time
SIGNATURE shows that caregiver has met goals

RT	DATE	SIGNATURE
- Aerosol Treatments		
- Cleaning and changing circuits/humidifier		
- Ventilator battery on charge		
- A/C power cord plugged into wall outlet		
NURSING	**DATE**	**SIGNATURE**
- Arrange two-way transportation		
- W/C sitting tolerance of at least 8 hours		
- Application of external catheter, leg bag, ????		
- Does I.C.		
- Has Dysreflexia Alert card		
- Has seen skin slides		
- Skin inspection and recognizing pressure area demonstrated		
- Bowel Program		
- Able to administer medications		
- Bathing and dressing of patient		
- Positioning		
- Trach care		
- G.T. feeding/care/insertion		
- Equipment maintenance (W/C, suction machine charging)		
- Percussion and postural drainage		
- Biomedical		

I hereby acknowledge having undergone the above training, and I understand and hereby acknowledge receipt of the above information.

______________________________ Caregiver's Signature ________ Date

______________________________ Nursing Signature ________ Date

☐ Training Not Completed
Reason:

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER
County of Los Angeles Department of Health Services

RD655 (N2-95)

CRITERIA FOR PASS FOR
VENTILATOR DEPENDENT PATIENT TYPE III

Original To Be Placed In Medical Record
Copy To Be Provided To Caregiver

NAME
RLAMC #
B.D., SEX

UNIT

Month-Day	Year	

County of Los Angeles Department of Health Services
Rancho Los Amigos National Rehabilitation Center

CRITERIA FOR PASS
VENTILATOR DEPENDENT PATIENT TYPE III

PT'S NAME

R#
DOB