NDIS LWB 5672 Non-Invasive Ventilator CPAP BiPAP Support - Plan

- This CPAP/BiPAP Support Plan must be developed with the person we support and their Health Practitioner.
- The CPAP /BiPAP Support Plan must be overseen by the Health Practitioner.
- **Staff members must be appropriately trained to administer or dispense medication and undertake any Non-Invasive Ventilator Support Procedures.**
- This CPAP/BiPAP Support Plan should be read in conjunction with the relevant policies and procedures.

Personal Details *(to be completed by staff & person we support)*			
Name:		**CIRTS ID:**	
Date of Plan:		**Review Date:**	

Risks and Emergency Response
Risks
When to call an ambulance
When to seek medical assistance

My Support includes:				
Procedure – (who is responsible)	Me	LWB DSW	Health Professional	Other
☐ Ventilator Circuit Change (tube from machine to mask)	☐	☐	☐	
☐ Apply mask	☐	☐	☐	
☐ CPAP	☐	☐	☐	

☐ BiPAP	☐	☐	☐	
☐ Clean mask and tubing	☐	☐	☐	

My Preferences *(Completed by the person we support or their Support Network)*

I like my ventilator circuit (hose from machine to mask) to be changed every

I like the filter on my CPAP or BiPAP to be changed every

I prefer to use a:	If I cannot breathe through my nose due to being unwell, I use:
☐ Nasal pillow ☐ Nasal mask ☐ Full face mask ☐ Oral mask ☐ Other	☐ My usual mask ☐ Full face mask ☐ No mask – but require regular monitoring as per instructions below.

My Equipment: *(Completed by the person we support or their Support Network)*

Refer Tracheostomy Procedure for tracheostomy and suctioning equipment

Item	Description	Who orders this	How often	Where
Ventilator Tubing				
CPAP or BiPAP				
Mask				
Back up battery				
Pulse Oximeter				
Other				

CPAP or BiPAP Settings: *(Completed by Health Professional / Respiratory Specialist)*

Start at (cmH_20) and increase to (cmH_20)

Person specific support requirements *(To be completed prior to completion/approval by the AQHP)*

Record any information specific to the person's support needs in relation to this plan.

LIFE WITHOUT BARRIERS

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Details about any specific changes or preferences staff must know in order to support the person with this plan: *(This section must be completed by the Health Professional)*
☐ Not Applicable, the person's supports do not require any modification.
☐ Modifications are required as follows:

Details about how to support the person while they have a cold or illness affecting their ability to wear their mask. *(Completed by Health Professional)*

In the event of an emergency, please contact <u>000</u> plus *(Completed by staff & the person we support)*:			
Name:		**Contact Number**	
Relationship			
Name:		**Contact Number**	
Relationship			

Plan developed by: *(completed by Health Professional(s))*			
Name:		**Profession:**	
Contact details:		**Date:**	
Name:		**Profession:**	
Contact details:		**Date:**	

Review of Plan *(completed by Health Professional)*		
☐ **Set review:**	**Date:**	
Signature:		

☐ **As needed review:** This plan will be reviewed following

- a problem being identified while following this plan
- a new risk being identified
- advice from the person's GP/ Allied Health Professional

Consent and Authorisation

I consent to the support requirements in this Plan to be implemented in order to assist in the management of my health supports or receive general emergency response as required. If I am unable to give consent, LWB will seek consent from my guardian/person responsible.			
Name	**Relationship**	**Signature**	**Date**
	Self		
	Guardian / Person Responsible		
	LWB Line Manager		

Upload to CIRTS as follows:
Plans & Assessments > New Plan > Service Type = the service providing the HIDPA > Plan name – [select from drop down] Ventilator Management Plan > relevant dates > Add New Attachment > SURNAME, First Name. YYYY.MM.DD