EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Validation Checklist

1:1 ALS Program Orientation / Competencies
Oropharyngeal Airway (OPA)

NAME: ____ **ID#** ________________________
(Please Print)

JOB POSITION: ______________________ **INITIAL:** ☐ **RENEWAL:** ☐ **DATE:** _________

<table>
<tr><th colspan="5">PREPARTATION</th></tr>
<tr><th colspan="2">Performance Criteria</th><th>YES</th><th>NO</th><th>Comments</th></tr>
<tr><td colspan="2">Establishes appropriate BSI precautions</td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">States the indications for insertion of an oropharyngeal airway (OPA).</td><td>Unresponsive without a gag reflex</td><td></td><td></td><td rowspan="2"></td></tr>
<tr><td>Unresponsive apneic patient needing positive pressure ventilations with a bag-mask-ventilation (BMV) device</td><td></td><td></td></tr>
<tr><td rowspan="4">States the contraindications for the use of an OPA</td><td>Conscious or semi-conscious</td><td></td><td></td><td rowspan="4"></td></tr>
<tr><td>Conscious or semi-conscious with gag reflex</td><td></td><td></td></tr>
<tr><td>Clenched teeth</td><td></td><td></td></tr>
<tr><td>Oral trauma</td><td></td><td></td></tr>
<tr><td rowspan="2">Selects appropriate size by measuring the OPA from:</td><td rowspan="2">Corner of the mouth to tragus or earlobe
(OR)
Center of the mouth to the angle of the jaw</td><td></td><td></td><td rowspan="2"></td></tr>
<tr><td></td><td></td></tr>
<tr><th colspan="5">INSERTION OF OPA PROCEDURE</th></tr>
<tr><th colspan="2">Performance Criteria</th><th>YES</th><th>NO</th><th>Comments</th></tr>
<tr><td colspan="2">Opens the mouth by applying pressure on the chin with thumb and removes any visible obstructions – if indicated</td><td></td><td></td><td></td></tr>
<tr><td rowspan="3">Inserts the OPA airway into the pharynx by inserting tip:</td><td rowspan="3">Toward the hard palate and rotate 180°
(OR)
Straight and displacing the tongue interiorly
(OR)
Sideways and displacing the tongue anteriorly and rotate OPA 90°</td><td></td><td></td><td rowspan="3"></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">Advances the airway until the flange rests on the lips</td><td></td><td></td><td></td></tr>
</table>

Performance Criteria		YES	NO	Comments
Re-assesses airway patency and breathing	Skin color			
	Chest rise and fall			
	Upper airway sounds			

REMOVAL OF OROPHARYNGEAL AIRWAY

Performance Criteria	YES	NO	Comments
Removes airway by grasping the flange and guiding it down toward the chin			
Suctions the oropharynx – *if indicated*			
Places a pulse oximeter on the patient			
Administers oxygen via appropriate method - *if indicated* *(Mask, N/C, BMV)*			
Re-assess airway patency and breathing: *(same as above)*			
Disposed of contaminated equipment appropriately			

Validator Attestation Statement for OPA Competency: ***My signature below indicates that I have reviewed/validated each line item and that completion by the employee occurred on the date stated at the top of this document.***

VALIDATOR NAME / SIGNATURE: ____ DATE: _____________
(Print Name & Sign)

☐ I understand the content and have completed the above competency assessment and verification process. I believe that I am a competent provider of this service as a result of training, experience and / or competency verification.

☐ I understand that I have not met the criteria needed to verify that I am competent provider of this service. I agree to participate in additional leaning activities as assigned in order to meet criteria.

■ I also understand that this form will be kept in my education file and is available upon request.

EMPLOYEE NAME / SIGNATURE: ____ DATE: ______________
(Print Name & Sign)