



BTS/ICS Guidancee Spiratory care inpatients with Acute Hypoxaemic Respiratory Failure associated wit BOVID19

This guidance refers the use of Continuous Positive Airway Press (P, High-Flow Nasal Oxygehi (N) and Non Invasive Ventilation (NIV) therapyfor patients with acute hypoxaemire spiratory failures econdary to COVID19. Patients with COVID19 may be looked after on general wards, respiratory support units (RSt) tical care units and this **do**ment offers guidance for which patients could be looked after intron-critical caresettings and what criteria should be used for scalation to areas with higher acuity treatments. (See Appendix 1 COVID9 Respiratory Support Pathwallow Forkart)

The trigger for consideration for escalation of patients on general wards to an RSU should be the inability to maintain oxygen saturations 194% on an inspired oxygen <40% areful considerations to the suitability of escalation to RSU should be made senior level (ST3+ and after scussion with the onsultant overseeing the patient's care) and following consultation with respiratory and/or critical care medicine.

Specifications for Respiratory Support Units will be published by BTS and ICS 202211/. i Units should meet the following criteria.

Structures

- x Appropriate Infection Control Precautions should be in place including: Isolation facilities where required, PPE appropriate for AGP, CPAP/NIV circuit set up as per BTS guidance.
- x Oxygen utilisaton-Liaison with medical gas committee or oxygen engineering team is required before establishing an RSU.
- x Multiple open respiratory circuits may increase ambient oxygen concentrations. Consideration should be givenet a oxygen concentrations, verhation, humidity and fire risk.

Treatment

A locally developed acute CF/AFFNØNIV protocol (based on published best practice guides) uld be uniformly applied across all areas.

Patients treated with CPARFNONIV will benefit from a team approach using the collective expertise gained by respiratory and critical care multidisciplinary teams during the first wave in March 2020. Staffing

A clinical lead for each of respiratory medicine, nursing and physiotherapy should be identified.

All staff should have appropriate experience and demonstrable competence in the managemention as a support.

Staffing ratios should reflect the acuity of support required and where patientside adependent due ogively to End Tidal CO2 (ETCO2) monitoring to help identify machine disconnection in CPAP/NIV dependent patients but ETCO2 must not be used to estimate values or trends in arterial CO2.

Escalation

Establish a treatment escalation plan admission.

Daily liaison between ward teams and critical care should be normal practice with decisions regarding escalation to critical care being made at senior lev(ST3+ and with discussion with consultant overseeing the patient's care) and following consultation with critical care medicine.

Regular assessment of success/failure of **inoma**sive respiratory suppositional be undertaken. Signs of CPARTNONIV failure include limited

Guidance based on available evidence and expert opinion. Variations to this advice may be required get endinal setting and individual patients