Per Shift Ventilated Patient Nurse Checklist **Patient name and hospital number:**

Checks	Date																					
	Shift	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N
Self–inflating bag and mask connected to oxygen? Turn on and check. Manual hyperinflation bag + catheter mount + **red cap**?																						
Suction check Pressure 150mmHg/20kPa max? Canister not > ½ full?	**See "Tracheostomy Emergency Equipment Check List" and "Daily Record of Tracheostomy Care"**																					
Suction catheter size correct for trachy size? (size 7 trachy = suction 12 max/ size 8 trachy = suction 14 max)																						
Closed system suction changed in last 72hrs (3days)? (check yellow sticker)																						
Closed system suction flushed after each suction session?																						
Alarms/vent checks: • F & P humidifier water >300mls? • Pulse oximeter alarms Hi P Low P Hi Sat Low Sat • Bedside and back up ventilator prescription check Any discrepancies: unlock the machine and change settings to those on prescription; lock machine again then check settings with a competent colleague.																						
Ventilator charging: Ensure second ventilator plugged in and charging when not in use (either on w/c or at bedside on suitable surface - not on floor)																						
Weaning patient: Check humidifier turned on/off with ventilator Check cuff down when weaning Check FVC measured pre and post wean + document on chart																						
Daily changes/cleaning: • Yankauer sucker, suction canister and tubing change. • Dry circuit HME change / Swedish nose change • Per Shift change Inner Cannula • Ventilator circuit end covered with **red cap** when not in use & hung up. Clean with detergent wipes: ventilators x 2, F & P, oximeter /bedside trolley & surfaces																						
Patient Specific Checks – 'line-of-sight' care required? Y/N **New admission suction B5 or B3 under supervision 1st 72 hours.**																						
Weekly changes: **(check and use yellow stickers)** • Wet circuit • Dry circuit • White air intake filter (change) • Grey air intake filter (wash and dry) • Nebuliser chamber/tubing • Oxygen tubing • T-piece/trachy mask and elephant tubing • Suction jug for flushing suction																						
Weekly check Blue "Trachi-Case" **Date checked:** OPEN BOX, check contents against list on lid including expiry dates; then seal handle with yellow sticker	**See "Tracheostomy Emergency Equipment Check List"**																					
RN Initials:																						

Daily Respiratory Patient Risk Assessment Tool **Patient name:**

Enter Total score (0+ 1+ 2+3) into the scoring box. Repeat scoring daily.

	Score 0	Score 1	Score 2	Score 3	Date	Date	Date	Date	Date	Date	Date
Mode+ time on ventilation	Not ventilated for any part of 24 hours	Intermittent Pressure Support or NIV	Weaning requiring ventilation for more than 12 hours.	Not weaning PCV (A) PSV (A) VCV							
Interface	Not ventilated	Nasal mask/ mouth piece	Full facial mask	Tracheostomy							
Apnoea risk	Self-ventilating for 24 hours	Able to breath consistently off ventilator only when awake		Dependent on ventilatory support for 20 hours or more							
Communication	Able to verbally call for help if needed	Able to use hand bell or additional device to call for help		Unable to call for help verbally without relying on nurse call							
Airway clearance and cardiovascular stability	Occasional need for tracheal suction or manual assisted coughing– less than once in 24 hrs	Daily suction **OR** Cough Assist /manual assisted cough treatment only	Routine, predictable or prophylactic tracheal suctioning and Cough Assist /manual assisted cough Rx.	Unpredictable / urgent Rx due to one or more of: • O2 Saturations often below prescribed target • Frequent or unpredictable tracheal suctioning /manual assisted cough/ cough assist requirement • Requires hourly intervention by competent respiratory staff							
				Score:							
				RN initials:							

Risk reduction plan: **Consider use of listening device/'baby' monitor for at risk patients.**

Score 2 – 8 = At Risk : Follow spinal respiratory care plan*, continuous oxygen saturation monitoring. Regular intentional rounding. Consider need for competent respiratory staff in line of sight.

Score 9 -13 = Medium Risk : Follow spinal respiratory care plan*, continuous oxygen saturation monitoring, competent respiratory staff band 3 and above in line of sight, 1:2 nursing ratio.

Score 14 = High Risk : Follow spinal respiratory care plan*, continuous oxygen saturation monitoring, competent respiratory staff 1:1 band 3 and above

Score 15 = Very High Risk: Follow spinal respiratory care plan*, continuous oxygen saturation monitoring, competent respiratory staff 1:1 band 3 and above, consider Spinal Consultant d/w ITU.

Trigger: If staffing levels do not meet the combined needs of ventilated and non-ventilated patients inform Spinal Bleep Holder to manage/ escalate situation as appropriate (e.g. site manager). If identified staffing levels are still not met complete Datix + Allocate 'Safe Care' comment.