

High Flow Nasal Oxygen (HFNO) Pathway

For use on Laverstock Ward only

|  |  |
| --- | --- |
| Patient Name |  |
| Date of Birth |  |
| Hospital Number |  |
| Location |  |
| Consultant |  |
| Date NHF commenced |  |

**Please complete all section of this form before commencing HFNO therapy**

**Section 1: Signature Log** (To be completed by the medical practitioner and registered nurse)

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| --- | --- | --- | --- |
| **Designation** | **Name** | **Signature** | **Date** |
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| --- | --- |
| **Section 1** | To be completed by the medical practitioner and registered nurse |
| **Section 2** | To be completed by the medical practitioner |
| **Section 3** | To be completed by the medical practitioner |
| **Section 4** | To be completed by the medical practitioner |
| **Section 5** | To be completed by the medical practitioner |
| **Section 6** | To be completed by the medical practitioner or registered nurse  |
| **Section 7** | To be completed by the registered nurse  |

**Section 2: Patient Assessment** (To be completed by the medical practitioner)

|  |  |
| --- | --- |
| **Baseline Clinical Observations** | **Baseline Arterial Blood Gas** |
| Respiratory Rate |  | Date |  |
| SpO2 |  | Time |  |
| Added oxygen |  | Inspired O2 |  |
| Blood pressure |  | pH |  |
| Heart rate |  | pCO2 |  |
| Temperature |  | pO2 |  |
| AVCPU |  | HCO3 |  |
| NEWS2 |  | Base excess |  |

**Patient Diagnosis**

**CXR Findings**

**Does the patient have a pneumothorax: no 🞏 yes 🞏**

**Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: ­­­\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 3: Patient Optimisation and Risk Assessment** (To be completed by the medical practitioner)

Maximum standard medical treatment should be prescribed and evaluated prior to commencing HFNO. Please indicate by ticking the current management plan

|  |  |
| --- | --- |
| SpO2 Target | 1. to 92% 🞏

>94% 🞏 |
| O2 prescription | 🞏 |
| Bronchodilators | 🞏 |
| Steroids | 🞏 |
| Antibiotics | 🞏 |
| Hydration | 🞏 |
| Aminophylline | 🞏 |

**Contraindications -** Does the patient have any of the following

Patients for escalation to ITU/HDU ⚫ Basal skull fracture ⚫ unconscious patient ⚫ inability to protect own airway ⚫ Nasal passage abnormalities or recent nasal surgery ⚫ Cerebro-spinal fluid leaks ⚫ untreated pneumothorax ⚫ severe epistaxis

 Yes 🞏 No 🞏

Has the patient declined therapy? Yes 🞏 No 🞏

Patient judged not to be able to tolerate the therapy Yes 🞏 No 🞏

**If yes to any of the above questions, this therapy should not be commenced on Laverstock Ward**

**Relative contraindications -** Does the patient have any of the following

Patients at risk of acute hypercapnia secondary to oxygen therapy ⚫ altered conscious level but able to maintain airway ⚫ thrombocytopaenia ⚫ asthmatic ⚫ irreversible decline of chronic condition? Yes 🞏 No 🞏

**If yes to any of the above questions, this therapy should only be commenced after a discussion with the respiratory consultant, respiratory SpR or intensivist**

**Section 4: Treatment Plan** (To be completed by the medical practitioner)

**Relative contraindication identified but decision to commence therapy**

Please identify any member of the team involved in the decision making and rationale for commencing therapy

Based upon the assessment, is this patient still a candidate for high flow nasal oxygen? Yes 🞏 No 🞏

**Medical healthcare professional completing this assessment**

Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: ­­­\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient fails to improve, what is the escalation plan?

RESPECT form completed 🞏

**Section 5: High Flow Nasal Oxygen Prescription Chart** (To be completed by the medical practitioner)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Initial set up** | **Setting change**  | **Setting change** | **Setting change** | **Setting change** | **Setting change** |
| **Date** |  |  |  |  |  |  |
| **Time**  |  |  |  |  |  |  |
| **Flow l/min** |  |  |  |  |  |  |
| **O2** |  |  |  |  |  |  |
| **Temperature** |  |  |  |  |  |  |
| **Name** |  |  |  |  |  |  |
| **Signature** |  |  |  |  |  |  |
| **Grade** |  |  |  |  |  |  |

**Section 6: Treatment Evaluation – arterial blood gas or ear lobe capillary sample**  (To be completed by an appropriate healthcare professional)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** |  |  |  |  |  |  |  |  |  |
| **Time** |  |  |  |  |  |  |  |  |  |
| **Sample type** |  |  |  |  |  |  |  |  |  |
| **pH** |  |  |  |  |  |  |  |  |  |
| **pCO2** |  |  |  |  |  |  |  |  |  |
| **pO2** |  |  |  |  |  |  |  |  |  |
| **HCO3** |  |  |  |  |  |  |  |  |  |
| **Base excess** |  |  |  |  |  |  |  |  |  |

**Section 7: Nasal High Flow Oxygen Observation Chart** (To be completed by the registered nurse)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** |  |  |  |  |  |  |  |  |  |
| **Time**  |  |  |  |  |  |  |  |  |  |
| **Flow l/min** |  |  |  |  |  |  |  |  |  |
| **Oxygen %** |  |  |  |  |  |  |  |  |  |
| **Respiratory rate** |  |  |  |  |  |  |  |  |  |
| **SpO2** |  |  |  |  |  |  |  |  |  |
| **Chamber temp** |  |  |  |  |  |  |  |  |  |
| **Water level** |  |  |  |  |  |  |  |  |  |
| **Signature**  |  |  |  |  |  |  |  |  |  |
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| **Date** |  |  |  |  |  |  |  |  |  |
| **Time**  |  |  |  |  |  |  |  |  |  |
| **Flow l/min** |  |  |  |  |  |  |  |  |  |
| **Oxygen %** |  |  |  |  |  |  |  |  |  |
| **Respiratory rate** |  |  |  |  |  |  |  |  |  |
| **SpO2** |  |  |  |  |  |  |  |  |  |
| **Chamber temp** |  |  |  |  |  |  |  |  |  |
| **Water level** |  |  |  |  |  |  |  |  |  |
| **Signature**  |  |  |  |  |  |  |  |  |  |

**Section 7: Nasal High Flow Oxygen Observation Chart** (To be completed by the registered nurse)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** |  |  |  |  |  |  |  |  |  |
| **Time**  |  |  |  |  |  |  |  |  |  |
| **Flow l/min** |  |  |  |  |  |  |  |  |  |
| **Oxygen %** |  |  |  |  |  |  |  |  |  |
| **Respiratory rate** |  |  |  |  |  |  |  |  |  |
| **SpO2** |  |  |  |  |  |  |  |  |  |
| **Chamber temp** |  |  |  |  |  |  |  |  |  |
| **Water level** |  |  |  |  |  |  |  |  |  |
| **Signature**  |  |  |  |  |  |  |  |  |  |
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| **Date** |  |  |  |  |  |  |  |  |  |
| **Time**  |  |  |  |  |  |  |  |  |  |
| **Flow l/min** |  |  |  |  |  |  |  |  |  |
| **Oxygen %** |  |  |  |  |  |  |  |  |  |
| **Respiratory rate** |  |  |  |  |  |  |  |  |  |
| **SpO2** |  |  |  |  |  |  |  |  |  |
| **Chamber temp** |  |  |  |  |  |  |  |  |  |
| **Water level** |  |  |  |  |  |  |  |  |  |
| **Signature**  |  |  |  |  |  |  |  |  |  |