

- Controlled Oxygen therapy aim 88-92%
- Nebulisers, steroids and Antibiotics
- Drugs discontinued as appropriate
- \*\* 1 in 5 patients improve on medical management

resolution? YES Continue medical management. Admit to 5B/AMU, monitor and document future NIV plan

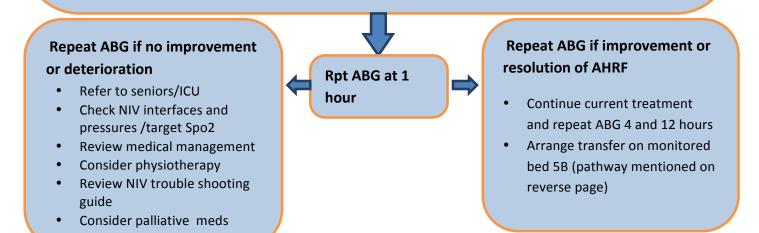
**Repeat ABG post medical management if persisting respiratory acidosis** or if patient deteriorating clinically and consistent with AHRF?

**Check CXR** to rule out pneumothorax and arrange FBC, U&E, LFT and inflammatory markers, check EPR for previous escalation and management plan.

**Start NIV (BIPAP)-** Start pressure IPAP/EPAP- 12/5, Backup RR– 12, Usual Target pressure- IPAP/EPAP- 20/5 **Document:** 

- Diagnosis of COPD/OSA or OHS (AHRF and somnolent)/Spine or chest wall deformity (acidotic AHRF), Neuromuscular disease (hypercapnia)
- Is this patient a candidate for ICU escalation if NIV fails?
- Has this plan been discussed with patient and/or relatives?
- Is this NIV a ceiling of care?
- Has DNACPR decision made and documented on EPR?

Maximum IPAP should be titrated against tolerability. Patient with NMD or frail patients may require lower IPAP, however OSA/OHS may need high IPAP (25-30)





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#### **Responsibility of Medical Team**

- Establish indications/Contraindications
- Make escalation/Ceiling of care decision.
- Request A&E co-ordinator for NIV bed.
- Document DNACPR and discuss with patient and family.
- Clearly Document future plan of management on EPR (initial ABG, NIV settings) including when, how and whom to contact if patient deteriorates
- Arrange 1hour, 4 hours ABG and clinical review

#### Indication for ICU referral if appropriate for escalation

- •AHRF in Asthma
- •AHRF with impending respiratory arrest •NIV treatment failure: decreased chest wall movement, unable to decrease PaC02
- Inability to maintain target Sp02 on NIV
- Need for IV sedation, closer monitoring +/possible difficult intubation

## **Disease Specific Indications:**

**COPD**: pH < 7.35 AND PaC02 ≥ 6.5 RR > 23 despite one hour of medical management Neuromuscular Disease: Respiratory illness with RR >20 if usual VC <1L or pH < 7.35 AND PaC02 ≥ 6.5

**Obesity:** pH < 7.35 AND PaC02 ≥ 6.5, RR > 23 or daytime  $PaCO2 \ge 6.0$  and drowsy NIV is not usually indicated in Asthma

## **Contraindications:**

**Absolute:** Undrained pneumothorax, facial burns, fixed upper airway obstruction, for at least two weeks post oesophagectomy

**Relative:** pH < 7.15, GCS < 8, confusion/agitation, cognitive impairment, vomiting (consider NG tube)

Admit on 5B/AMU on a monitored bed with clear plan and parameters needing escalation to medical registrar/ICU medical team/Outreach team

Continuous cardiac and Spo2 monitoring should be done at least for 12-24Hr

# **Complete NIV Care Bundle and Prescription on EPR**

## NOTE

- NIV patient at HRI A&E should get admitted on HRI Medical admission unit on a monitored bed/HDU/ICU – Involve outreach and Refer to Respiratory in-reach/respiratory consultant of the week
- Transfer to 5B once fit for transfer and inform respiratory consultant covering ward 5B
- Deteriorating Patients on wards both sites should get NIV started ASAP on ward and follow pathway