AIRVO2™ High Flow Nasal Oxygen (HFNO/HFO) PRESCRIPTION for Acute Respiratory Failure

South Tees Hospitals NHS
NHS Foundation Trust

WRITE OR ATTACH ADDRESSOGRAPH	
Surname________________________	Date________________ Time__________
Forenames______________________	Unit/Ward__________________________
DOB dd / mm / yyyy Age______	Speciality__________________________
Hospital number_________________	Consultant__________________________
NHS number____________________	Prescriber______________ Grade__________

Requested by (name/grade) ____

☐ Senior doctor aware - NAME ____

☐ Nurse in charge aware - NAME ____

Please complete the following at the time of initiating HFNO/HFO Therapy AIRVO2

Reason to start HFNO/HFO therapy *(check all that apply)*	☐ Respiratory Failure Type 1 ☐ Respiratory Failure Type 2 ☐ Break or weaning from NIV/CPAP ☐ Humidification ☐ Post-op care (laryngectomy) ☐ Other____________________ ☐ Palliative Care *(make sure palliative care team is informed and involved; only use for short term)*
Current diagnosis	☐ AECOPD ☐ Pneumonia ☐ Pulmonary Oedema ☐ Post-op respiratory failure ☐ Viral pneumonitis_______________ ☐ Other ____________________

ABG or CBG prior HFNO/HFO Therapy AIRVO2 (if available)

DATE/TIME________________________ ☐ ABG ☐ CBG FiO_2__________ Interface__________

SaO_2__________ pH__________ pO_2__________ pCO_2__________ BE__________ HCO_3^-__________

NEWS2 prior HFNO/HFO therapy AIRVO2 ________________	RR_______ SpO_2_______on FiO_2_______ BP_____/_____ HR_______ Temp_______ GCS______ /15_ Acute confusion/Agitation Yes/No

Are there any contraindications to HFNO/HFO therapy AIRVO2? ☐ NO ☐ YES (check below)

☐ Respiratory arrest
☐ Peri-arrest
☐ Moribund
☐ Severe cardiovascular instability

☐ Life threatening hypoxemia
☐ Patients at risk of hypercapnia
☐ Profound hypercapnia
☐ Decreased conscious level
☐ Basal skull fractures

☐ Cerebro-spinal fluid (CSF) leaks
☐ Oesophagectomy (limit flow to 30 L/min)
☐ Nasal passage abnormalities or recent nasal surgery (avoid nasal cannula)
☐ Laryngectomy (only use with tracheostomy mask connector)

Please complete a STEP form and discuss escalation therapy if there was no response to HFNO/HFO therapy. Is this patient for NIV/CPAP (Yes/No) or Invasive Ventilation (Yes/No)?	☐ STEP form completed Date / Time __________ Name ______________________________ Grade ______________ Reg no ______________

Patient Name ____DOB_____________Hosp no__________________

TARGETS: SpO_2 ________________ pO_2________________ pCO_2 ___________________(on arterial or capillary BG)

INITIAL SETTINGS

Interface	Oxygen (FiO_2 %)	FLOW (L/min)	Temperature (°C)
☐ Nasal cannula (OPTIFLOW) ☐ Face Mask Connector ☐ Tracheostomy Mask Connector			

Set by (Name / Reg. no) ____

Date/Time_______________

CHANGE OF SETTINGS

Date / Time	Changed by (Name/Reg no)	Reason for change	Interface	Oxygen (FiO_2 %)	FLOW (L/min)	Temperatu re (°C)

COMMENTS LOG *(include change of interface / incidents /troubleshooting)* Please Date and Sign